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Supreme Court, U.S.
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No. 87-

IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

GENERAL MOTORS CORPORATION and
AMERICAN NATIONAL RED CROSS,
Petitioners,

v.

WILLIAM M. BENNETT, CONWAY H. COLLIS,
ERNEST J. DRONENBERG, JR., RICHARD NEVINS,
GRAY DAVIS, and BRUCE BUNNER,
Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

Of Counsel:

STEPHEN M. SHAPIRO

MAYER, BROWN & PLATT
190 S. La Salle Street
Chicago, Illinois 60603
(312) 701-7327

PAUL D. INMAN

GIBSON, DUNN & CRUTCHER
1050 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 955-8500

STEPHEN E. TALLENT
*WILLIAM J. KILBERG

GIBSON, DUNN & CRUTCHER
1050 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 955-8500

Attorneys for Petitioners

**Counsel of Record*

PRESS OF BYRON S. ADAMS, WASHINGTON, D.C. (202) 347-8203

QUESTION PRESENTED

ERISA preempts "all State laws" that "relate to" employee benefit plans except, *inter alia*, those which also "regulate insurance." 29 U.S.C. § 1144. The State of California taxes insurance companies that provide excess-risk insurance to ERISA employee welfare benefit plans. The tax is calculated based on the amounts paid by plans for insurance *and* the amounts paid by plans to employees in benefits. The question in this case is whether section 514 of ERISA, 29 U.S.C. § 1144, preempts the tax insofar as it is assessed on the amounts paid by plans to employees in benefits.*

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* Petitioners' statement pursuant to Rule 28.1 of the Rules of this Court is set forth in the Appendix at 1a.

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Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

General Motors Corporation ("GMC") and the American National Red Cross ("Red Cross") respectfully petition this Court to issue a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit to review that court's holding that the states can tax ERISA-covered welfare benefits if the legal incidence of the tax falls on the plan's insurance company.[1] The Court of Appeals justified elevating the

[1] Respondents are state officials responsible for administering the challenged tax. The Court of Appeals vacated the District

formal incidence of the tax over its substance by asserting that this Court's decision in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985), required that result. Thus, only this Court can resolve whether it in fact intended the *Metropolitan* decision to sanction indirect—but purposeful—state taxation of ERISA benefits notwithstanding ERISA's command that "any State tax law relating to employee benefit plans" be preempted. 29 U.S.C. § 1144(b)(5)(B)(i).

OPINIONS BELOW

The United States District Court for the Central District of California entered judgment in favor of petitioners GMC and the Red Cross in an initial opinion reported at 600 F. Supp. 76, and a modified opinion reported at 626 F. Supp. 439. Appendix at 16a, 25a. The United States Court of Appeals for the Ninth Circuit reversed the District Court in an opinion reported at 815 F.2d 1305. Appendix at 3a. The Ninth Circuit denied appellees' Petition for Rehearing with Suggestion for Rehearing En Banc in an unreported opinion on August 14, 1987. Appendix at 35a.

JURISDICTION

The Court of Appeals rendered its decision reversing the District Court's judgment in favor of petitioners on April 24, 1987, and denied petitioners' timely Petition for Rehearing on August 14, 1987. On October 31, 1987, Justice O'Connor granted petitioners' application to extend to December 14, 1987 the time in which to file a Petition for Writ of

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Court's injunction against the principal agency in the taxing process, the California State Board of Equalization, on Eleventh Amendment grounds. Appendix at 10a.

Certiorari. Petitioners invoke the jurisdiction of this Court pursuant to 28 U.S.C. § 1254(1).

STATUTES INVOLVED

1. Section 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144(a) (emphasis added), provides in part:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan . . . .

2. Section 514(b)(2)(A) of ERISA (the "saving clause"), 29 U.S.C. § 1144(b)(2)(A) (emphasis added), provides:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which *regulates insurance*, banking, or securities.

3. Section 514(b)(2)(B) of ERISA (the "deemer clause"), 29 U.S.C. § 1144(b)(2)(B), provides in part:

> [No] employee benefit plan . . . shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts . . . .

4. Section 514(b)(5)(B)(i) of ERISA, 29 U.S.C. § 1144(b)(5)(B)(i) (emphasis added), provides:

> (B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section—
>
> (i) *any State tax law* relating to employee benefit plans

5. Section 514(c)(2) of ERISA, 29 U.S.C. § 1144(c)(2) (emphasis added), provides:

> The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly *or indirectly*, the terms and conditions of employee benefit plans covered by this subchapter.

STATEMENT OF THE CASE

A. Statutory Background

In 1974, Congress enacted the Employee Retirement Income Security Act ("ERISA"). Its "crowning achievement" was the "reservation to Federal authority the sole power to regulate the field of employee benefit plans." 120 Cong. Rec. 29197 (1974) (remarks of Rep. Dent). To accomplish that end, Congress enacted a reticular set of provisions designed to shield plans from direct or indirect state action without unduly restricting the states' traditional authority in the fields of insurance, banking, and securities regulation. 29 U.S.C. § 1144.

In *Pilot Life Insurance Co. v. Dedeaux*, 107 S. Ct. 1549 (1987), this Court summarized the "complexity" of ERISA's preemption provisions and recognized

Congress' intent, underscored repeatedly in the legislative history, to insulate employee benefit plans from any form of state intrusion:

> To summarize the pure mechanics of the provisions quoted above: If a state law "relate[s] to . . . employee benefit plan[s]," it is pre-empted. § 514(a). The saving clause excepts from the pre-emption clause laws that "regulat[e] insurance." § 514(b)(2)(A). The deemer clause makes clear that a state law that "purport[s] to regulate insurance" cannot deem an employee benefit plan to be an insurance company. § 514(b)(2)(B).
>
> . . . We have observed in the past that the express pre-emption provisions of ERISA are deliberately expansive, and designed to "establish [employee benefit] plan regulation as exclusively a federal concern." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523, 101 S.Ct. 1895, 1906, 68 L.Ed.2d 402 (1981). As we explained in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98, 103 S.Ct. 2890, 2900, 77 L.Ed.2d 490 (1983):
>
> > "The bill that became ERISA originally contained a limited pre-emption clause, applicable only to state laws relating to the specific subjects covered by ERISA. The Conference Committee rejected those provisions in favor of the present language, and indicated that section's pre-emptive scope was as broad as its language. See H.R.Conf.Rep. No. 93-

> 1280, p. 383 (1974); S.Conf.Rep. No. 93-1090, p. 383 (1974)."
>
> The House and Senate sponsors emphasized both the breadth and importance of the pre-emption provisions. . . .
>
> "It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law." [120 Cong. Rec.] 29933.
>
> . . . .
>
> Given the "statutory complexity" of ERISA's three pre-emption provisions, *Metropolitan Life, supra,* at 740, 105 S.Ct., at 2389, as well as the wide variety of state statutory and decisional law arguably affected by the federal pre-emption provisions, it is not surprising that we are again called on to interpret these provisions.

Id. at 1552-53.

B. The State Law at Issue

The State of California has the power to tax "gross premiums received" by insurance companies that do

business in the state. In *Metropolitan Life Insurance Co. v. State Board of Equalization*, 32 Cal. 3d 649, 186 Cal. Rptr. 578, 652 P.2d 426 (1982),[2] the California Supreme Court held that the phrase "gross premiums received" included not only the amount actually paid by an employee benefit plan to an insurance company to secure an excess-risk level of insurance coverage, but also the amount of benefits paid directly from the general assets of the sponsoring employer to employees and their dependents under the terms of the plan. *See* Appendix at 37a.

Under an excess-risk policy, the plan sponsors "are responsible for paying all claims up to a trigger point, an aggregate level of claims specified annually," and the insurance company "is responsible for paying all claims above that point." Appendix at 6a. The employee benefit plan remains largely "self-insured" or "uninsured" as a matter of federal law notwithstanding its purchase of an excess-risk policy. *See General Electric Co. v. Gilbert*, 429 U.S. 125, 128 n.3 (1976) (plan sponsor "remains, for all practical purposes, a self-insurer" notwithstanding purchase of "insurance policy from the Metropolitan Life Insurance Co."). As a consequence of the excess-risk arrangement, the insurance company does not receive from the plan, as it would under a "full insurance" arrangement, amounts used to pay expected (*i.e.*, pre-trigger point) benefits, but rather receives payment only for insuring against the risk of unexpected claim experience and for ancillary expenses.

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[2] The *Metropolitan Life* case, though decided in 1982, involved tax years preceding the 1974 passage of ERISA. The California Supreme Court thus did not address the preemption issue.

To reach its conclusion that benefit amounts not actually received by the insurer were nevertheless taxable as "gross premiums," the California Supreme Court first held that all employers that sponsor employee benefit plans are "mere agents" of insurance companies "as a matter of law." Appendix at 51a. The court then determined that the employer agents receive "premiums" from their employees by receiving the value of their labor. *Id.* at 54a-55a. Based on this two-step transfigurement of plan benefits into labor premiums constructively received by insurance agents, the court held that "the *entire cost of an employee benefit plan*, whether paid from the employer's funds or financed by deductions from the salaries of employees, *is taxable as gross premiums* inuring to the benefit of the insurer." *Id.* at 55a (emphasis added). By focusing on the cost of the plan rather than on the cost of the insurance purchased by the plan, the court upheld a tax on "insurance" that has no correlation to the degree or kind of insurance coverage actually purchased by the plan.

Following the California Supreme Court's decision, respondents issued a statement declaring their intention to interpret it as "broadly" authorizing the taxation of "payments made with employer funds" regardless of the particular characteristics of the insurance coverage purchased by the plan. Clerk's Record 18 at 108 (Insurance Bulletin No. 83-51, August 31, 1983). Indeed, respondents have applied the California Supreme Court's decision so as to assess benefits paid out, not only from all single-employer plans with any form of excess-risk insurance, but from multiemployer Taft-Hartley trust funds as well. *See* Appendix at 65a.

C. The Lower Courts' Decisions

GMC and the Red Cross,[3] in their capacities as plan sponsors and fiduciaries of ERISA welfare benefit plans insured through an excess-risk arrangement, brought suit in federal court claiming that section 514 of ERISA preempts California's inclusion of plan benefits in the amount subject to its "gross premiums" tax.[4] The District Court agreed, rejecting the State's assertion that it sought simply to tax the business of insurance:

> Defendants characterize the gross premium tax as an assessment against Metropolitan for doing business in California. *Yet, in fact, it is the amount which is paid out by the plaintiffs below the trigger point which is being treated as a premium received by Metropolitan and is being taxed.* Under ERISA this taxation practice is preempted because it "relates to" or bears some connection or

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[3] The trustees of the Motion Picture Health and Welfare Fund, a multiemployer Taft-Hartley fund, also joined in the suit, but were dismissed for lack of standing because the State had not yet actually sought to tax their fund's benefits. *See* Appendix at 28a. However, immediately following the District Court's ruling in favor of GMC and the Red Cross, the State proceeded to tax the Motion Picture Fund's benefits and the benefits of all plans except those of GMC and the Red Cross. The trustees in turn, with their standing thus secured, brought a second action, on behalf of themselves and a class of employee benefit plans, which the Court of Appeals has now dismissed in light of its decision below. *See* Appendix at 64a.

[4] Sections 502(e)(1) and 502(a)(3) of ERISA, 29 U.S.C. §§ 1132(e)(1) & (a)(3), grant exclusive jurisdiction to the federal district courts to resolve suits brought by plan fiduciaries to enjoin conduct preempted by section 514 of ERISA.

> reference to the plans by using the plans' payments as a means for measuring taxable premiums. *The defendants are indirectly taxing benefit payments and they are impeding the discretion of plan sponsors to fund their plan guarantees through a combination of general assets and excess risk insurance.*

Appendix at 32a (emphasis added).

The Court of Appeals did not disagree with the District Court's findings or the conclusion that the tax "relates to" plans through the "explicit use of plan payments in calculating the tax." Appendix at 12a. It concluded, however, that the tax was saved from preemption as one which "regulates insurance" because it is "intimately associated" with the business of insurance. *Id.* at 13a. Beyond the legal incidence of the tax, however, the Court of Appeals supported its "intimate association" conclusion solely by accepting the State's position that plan benefits reflect a taxable "cost" of insurance *regardless of the amount actually paid by the plan to purchase the insurance*:[5]

> Here, the premium paid the insurer includes only the loading element, so a method

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[5] The Court of Appeals found that the insurance arrangements in *Moore v. Provident Life & Accident Insurance Co.*, 786 F.2d 922 (9th Cir. 1986), and *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986), were both "similar to those in the case before us." Appendix at 14a. Both *Moore* and *Pacyga* hold that plans which purchase excess-risk policies remain largely "self-insured" or "uninsured." *Moore*, 786 F.2d at 927; *Pacyga*, 801 F.2d at 1162. The court below thus implicitly held that, once a plan purchases any level of insurance, the degree to which the plan is "insured" or "self-insured" does not determine the degree to which its benefits can be taxed.

> for determining the dollar amount of the net premium element is necessary [*i.e.*, to retain the same tax base as under a "full insurance" policy where both "elements" are paid to the insurer]. As the benefits paid by the plans equal the net premium under a traditional policy [*i.e.*, but not under the excess-risk policies at issue], appellants have referred to those payments in calculating the tax. *This reference . . . is used to measure the cost of insurance provided accurately* . . . .

Appendix at 13a (emphasis added). What the Court of Appeals' opinion never identifies is the subject of the clause "insurance provided." As the California Supreme Court itself acknowledged, the tax does not seek to measure only the cost of the insurance provided *by the insurer* to the plan, but also the imputed cost of the "insurance" [*i.e.*, benefits] provided *by the plan* to employees. It is this "entire cost of an employee benefit plan" rather than the cost of purchasing insurance that the tax seeks to measure "accurately." Appendix at 55a.

If a law purporting to "regulate insurance" treats a plan as an "insurer" or as "engaged in the business of insurance," then section 514(b)(2)(B) (the "deemer clause") overrides the insurance saving clause and reasserts federal preemption. Although the Court of Appeals acknowledged that the deemer clause is the "final step" in the preemption analysis, it found that the legal incidence of the tax foreclosed any inquiry into whether California's treatment of plan sponsors as "mere agents" of insurance companies, plan benefits as synonymous with insurance "premiums," and benefit-providing cost of a plan as equivalent to the

cost of "insurance" effectively deemed the plan to be an "insurer" or "engaged in the business of insurance":

> The tax at issue does not run afoul of the deemer clause. It is imposed on insurance companies, not benefit plans. It may affect benefit plans, but effects are not determinative. *Metropolitan* so holds. *Metropolitan* left intact a mandated-benefit law that had significant effects on Massachusetts plans. *In so doing, it indicated that state laws affecting benefit plans may escape preemption if they fall directly on insurance companies, as the tax at issue does.*

Appendix at 14a (emphasis added). GMC and the Red Cross here petition this Court to address whether it intended the *Metropolitan* decision to so broaden ERISA's saving clause and to so narrow its deemer clause as to permit the states to tax benefits paid out by ERISA plans as long as the legal incidence of the tax—though not its purpose or effect—falls on an insurance company.

REASONS TO GRANT THE WRIT

The decision of the Court of Appeals invites the states to dismantle the wall Congress explicitly sought to construct between plan benefits and the states' taxing power. *See, e.g.*, 29 U.S.C. § 1144(b)(5)(B)(i) (specifically referring to preemption of "any State *tax law* relating to employee benefit plans"); H.R. Rep. No. 655, Part I, 98th Cong., 2d Sess. 42 (1984) ("the Committee reasserts that a state *tax levy* on employee welfare benefit plans is preempted by ERISA"). Indeed, state taxation relating to employee benefit plans

poses a far more direct threat to those plans than state regulation. Whereas state regulation typically threatens to add only marginally to the administrative costs of maintaining the plan, state taxation directly decreases the funds otherwise available for providing health and pension benefits to employees and their dependents. Such state exactions from plan assets are contrary to the policy embedded at the core of ERISA preemption and are antithetical to the federal government's specific policy of exempting plan assets from its own taxing power.

Moreover, the tax at issue not only decreases amounts available for benefits, but also, as the District Court found, impedes the discretion ERISA grants plan sponsors in the selection of insurance arrangements that respond to a plan's need for coverage only in the event benefit claims exceed anticipated levels.[6] By upholding the imposition of a tax on the "entire cost" of a plan whenever it purchases any margin of insurance protection, the decision below encourages plans to forego that protection and thereby place at risk their ability to respond to unanticipated and perhaps catastrophic claim experience.

California is not alone in confronting plans with this funding dilemma of whether to purchase excess-risk insurance and thereby render all benefits subject to tax, or whether to sever all ties with insurance companies and thereby risk incurring uninsured cat-

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[6] Section 3(1) of ERISA, 29 U.S.C. § 1002(1), defines an "employee welfare benefit plan" as a program to provide certain listed kinds of benefits "through the purchase of insurance or otherwise."

astrophic losses. Texas has recently adopted California's benefit-as-premium theory.[7] There is no reason to believe that other states will not follow now that the Court of Appeals has sanctioned the indirect taxation of benefits. Moreover, the Court of Appeals' logic is not confined to any particular kind of plan insurance arrangement. Indeed, since the benefits themselves are deemed to entail an intrinsic cost of "insurance" taxable by the states so long as the legal incidence of the tax falls elsewhere, even plans that contract with insurance companies solely for administrative services may be vulnerable.[8]

It is not only the particular result the Court of Appeals reaches that is injurious to the federal interest, but also its far-reaching misconstruction of section 514. In a series of decisions, this Court has carefully interpreted the "statutory complexity" of ERISA's express preemption provision so as to affirm Congress's fundamental intent to preempt broadly any state law that "has some connection with or reference to" an employee benefit plan, unless that law can be said to "regulate insurance" within a "narrow," "common-sense understanding" of the term. *See Pilot Life Insurance Co. v. Dedeaux*, 107 S. Ct. 1549, 1554 (1987); *see also Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985) (state laws regulating content of insurance product "regulate insurance" within "common-sense view of the matter");

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[7] 1987 Tex. Gen. Laws, 70th Leg., 2d C.S., ch. 5, art. 8, at 57.

[8] The saving clause also protects state laws which "regulate . . . banking, or securities." Thus, if the Court of Appeals' approach were upheld, then the states would have an array of intermediaries through which to pass their benefit-based taxes.

Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 104 (1983) (section 514 combines an "all-inclusive pre-emption provision" with the "enumeration of narrow, specific exceptions").

The Court of Appeals, in contrast, employed the complexity of section 514 to frustrate rather than to further Congress' intent. As this Court has specifically recognized, "ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the pre-emption provision." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981). Here, however, the Court of Appeals permitted form to override the practical effects of a tax calculated with *necessary* reference to welfare plan benefits. The legal incidence of the tax does not alter the reality that California is taxing plan benefit activity and thereby imposing unrestrained economic burdens on plans that are indistinguishable from those which would result from direct taxation.[9] *See American Bank & Trust Co. v. Dallas County*, 463 U.S. 855, 862 (1983) (State "tax is barred regardless of its *form* if federal obligations must be considered, either directly or indirectly, in *computing* the tax" because "practical impact of such a tax is indistinguishable from that of a tax imposed directly . . . .") (emphasis in original); *Ramah Navajo School Board v. Bureau of Revenue*,

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[9] California estimated to the District Court that it alone stood to gain over $10 million a year from the benefit tax. Clerk's Record 14 at 2. Since the insurance companies naturally pass the benefit-related taxes directly through to the plans, the District Court found that California is, in economic effect, "indirectly taxing benefit payments." Appendix at 32a. The Court of Appeals did not disagree with that finding, but apparently found it irrelevant.

458 U.S. 832, 845 (1982) (regardless of the "legal incidence" of the tax, the tax is preempted because it " 'stands as an obstacle to the accomplishment of the full purposes and objectives of Congress' ").

Notwithstanding the Court of Appeals' assertions to the contrary, this Court's decision in *Metropolitan* is not controlling. The *Metropolitan* case simply held that a state law mandating a type of coverage in all group insurance policies, including those purchased by ERISA plans, is a law which "regulates insurance" within the meaning of the saving clause. The Court reached that conclusion after extensively examining the language, structure, and legislative history of section 514, as well as an analogous body of precedent defining—as a matter of federal law—the related phrase "business of insurance" in the McCarran-Ferguson Act. 15 U.S.C. § 1011 *et seq.* The Court of Appeals found, however, without any examination of the factors addressed in *Metropolitan*, that the saving clause preserves any state law that has an "intimate association" with the business of insurance, and, most critically, that the states themselves are free to create that association by deeming plan benefits to be "insurance premiums" intrinsically mirroring a taxable cost of "insurance."

This Court should not wait for a conflict to develop among the Courts of Appeals before recognizing, as in *Pilot Life*, the necessity to clarify the boundaries of the saving clause, particularly insofar as they are formed by the deemer clause. The Court of Appeals' wooden notion that the deemer clause is inapplicable whenever the state law is formally imposed on an insurance company, conjoined with its expansive deference to California's inventive equation of plan ben-

efits with "insurance premiums," provides the states with a blueprint for the evisceration of section 514. Moreover, employee benefit plans stand to suffer irreparable harm until this Court acts. In addition to the threat of uninsured losses confronting plans that abandon excess-risk coverage in the wake of the decision below, plan sponsors stand to forfeit permanently all amounts collected by the states prior to this Court's review because they have no avenue through which to pursue a refund. ERISA requires that plan sponsors bring their preemption challenges exclusively to federal court.[10] 29 U.S.C. § 1132(e)(1). The Eleventh Amendment, however, precludes those courts from ordering the states or their officials to refund any tax amounts they succeed in collecting. *See, e.g., Edelman v. Jordan*, 415 U.S. 651 (1974). The Court of Appeals' decision, though wrong, will make it difficult in states outside the circuit and impossible in those within it to secure preliminary injunctive relief. Accordingly, only action by this Court can forestall the irrevocable damage the decision of the Court of Appeals will otherwise inflict on benefit plans and benefit policy.

CONCLUSION

Petitioners do not challenge the power of the states to tax insurance companies even though the costs of the tax are passed through by the insurer to an ERISA plan. What they challenge is the power of the states to tax benefits paid out by ERISA plans under

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[10] Respondents concede that plan sponsors have no standing to pursue refund actions in state court and that they thus must rely completely on the ability and willingness of their insurers to undertake such an action.

the theory that such benefits constitute insurance premiums. Such taxation poses a far greater threat to the policy embodied in section 514 than any of the states' attempts to regulate plans previously examined by this Court. Both the result at issue and the reasoning invoked to reach it profoundly undermine the congressional will this Court has painstakingly identified and furthered in decisions from *Alessi* to *Pilot Life*. Petitioners accordingly respectfully ask that this Petition be granted and that the issues raised herein be set for the full consideration they deserve.

December 14, 1987

Respectfully submitted,

Of Counsel:

STEPHEN M. SHAPIRO

MAYER, BROWN & PLATT
190 S. La Salle Street
Chicago, Illinois 60603
(312) 701-7327

PAUL D. INMAN

GIBSON, DUNN & CRUTCHER
1050 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 955-8500

STEPHEN E. TALLENT
*WILLIAM J. KILBERG

GIBSON, DUNN & CRUTCHER
1050 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 955-8500

Attorneys for Petitioners

**Counsel of Record*

APPENDIX

APPENDIX A

The American National Red Cross has no subsidiaries or affiliates. General Motors Corporation's non-wholly-owned subsidiaries and affiliates are as follows:

Aralmex, S.A. de C.V. (Mexico)
Automotriz Gencor, S.A. (Ecuador)
Autos y Maquinas del Ecuador, S.A. (AYMESA) (Ecuador)
Comanis Nacional de Direcciones Automotrices, S.A. de C.V. (Mexico)
Compresores Delfa, C.A. (Venezuela)
Convesco Vehicle Sales GmbH (West Germany)
Daewoo Motor Co., Ltd. (Korea)
DHB-Componentes Automotives, S.A. (Brazil)
Fabrica Columbians de Automotores, S.A. ("Colomotores") (Colombia)
General Motors de Colombia, S.A. (Colombia)
General Motors Egypt, S.A.E. (Egypt)
General Motors Iran Limited (Iran)
General Motors Kenya Limited (Kenya)
GM Allison Japan Limited (Japan)
GM Fanuc Robotics Corp. (USA)
Industries Mecaniques Meghrebires, S.A. (Tunisia)
Industrija Delova Automobils, Kikinda (Yugoslavia)
Isuzu Motors Limited (Japan)
Isuzu Motors Overseas Distribution Corp. (Japan)
Kabelwerke Reinshagen GmbH (West Germany)
Kabelwerke Reinshagen Werk Berlin GmbH (West Germany)
Kabelwerke Reinshagen Werk Neumarkt GmbH (West Germany)
Moto Diesel Mexicana, S.A. de C.V. (Mexico)
Motor Enterprises, Inc. (USA)
Omnibus BB Transportes, S.A. (Ecuador)

Promotorade Partes Electronicos Automotrices (Mexico)
P.T. Mesin Isuzu Indonesia (Indonesia)
Senalizacion y Accessorios del Automobile Yorka, S.A. (Spain)
Unicables, S.A. (Spain)

APPENDIX B

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

GENERAL MOTORS CORPORATION; AMERICAN NATIONAL RED CROSS; JASPER BALLANCE; et al.,
Plaintiffs-Appellees,

v.

CALIFORNIA STATE BOARD OF EQUALIZATION; WILLIAM M. BENNET; CONWAY H. COLLIS; ERNEST J. DRONENBURG, JR.; RICHARD NEVINS; GRAY DAVIS*; and BRUCE BUNNER,
Defendants-Appellants.

No. 85-5618
D.C. No. CV-83-6801-DWW
OPINION

Argued and Submitted
February 5, 1986—Pasadena, California

Filed April 29, 1987

Before: Anthony M. Kennedy, Otto R. Skopil, Jr. and Arthur L. Alarcon, Circuit Judges.

Opinion by Judge Kennedy

Appeal from the United States District Court
for the Central District of California
David W. Williams, Senior District Judge, Presiding

*Substituted for Kenneth Cory, pursuant to Fed. R. App. P. 43(c)(1).

SUMMARY

Taxation

Appeal from a grant of summary judgment against a state taxing authority. Reversed.

The appellants, the California State Board of Equalization (State Board) and its individual members, administer a tax on gross premiums received by insurance companies doing business in the state. The appellees, including General Motors Corporation (and collectively referred to as GM), are fiduciaries of employee welfare benefit plans within the meaning of the Employee Retirement Income and Security Act of 1974 (ERISA), and fund plans providing disability and health care benefits with company assets and excess-risk policies from Metropolitan Life Insurance Company. By paying some of the claims themselves, and depending on excess risk policies for larger risks, the premiums paid Metropolitan were lower than under a traditional arrangement whereby larger premiums are paid and the insurance company pays all claims. In calculating the gross premiums tax assessed against Metropolitan, the appellants included premiums paid by the appellees to Metropolitan, plus benefits paid directly to employees under the plans. This method of calculation was upheld by the California Supreme Court. Appellee's contracts require that Metropolitan be reimbursed for premium taxes paid, so plaintiffs brought an action in federal court, seeking declaratory and injunctive relief, arguing that appellants' interpretation of the term "gross premiums ... received" was preempted by ERISA. The court granted appellees' motion for summary judgment.

[1] GM satisfies the requirements for standing, as they will have to pay the insurance company money they would not otherwise have to pay, and their injury is directly attributable to the tax, and would be fully redressed if the taxation were

enjoined. [2] Cases cited by the State Board do not defeat standing, as they lack either an allegation that the appellee's own rights have been violated or an express grant of standing. [3] The Tax Injunction Act applies only when a party has a plain, speedy and efficient remedy in state court. Since there is no state court remedy for GM in this case, and only Metropolitan can challenge the tax, the Tax Injunction Act does not apply. [4] Abstention is not proper in this case, since the preemption issue is one of federal law, [5] nor does the Eleventh Amendment preclude an award of injunctive relief.

[6] The district court's holding that ERISA preempts a premiums tax assessed against an insurer and calculated with reference to benefits paid by ERISA plans is reviewed de novo and reversed. [7] The Supreme Court has emphasized the broad scope of ERISA's preemption clause, [8] and though the clause is not all encompassing, the explicit use of plan payments in calculating the tax brings the preemption clause into play. [9] But the second step in the preemption analysis involves the insurance saving clause, which provides that any state law that regulates insurance, banking or securities shall remain in force. This clause must be interpreted broadly, [10] and must be construed to cover taxation of insurance. [11] The savings clause preserves the tax at issue, because the tax is intimately associated with the business of insurance. [12] Although the tax is calculated with reference to benefit payments, the payments are used only as a means of capturing the total cost of the insurance provided, the amount of which the State Board seeks to reach. [13] The final step in preemption analysis requires consideration of the deemer clause, which prevents a benefit plan being deemed to be an insurance company to prevent states from regulating benefit plans simply because they provide insurance. [14] But the tax here is imposed on the insurance companies, not the benefit plans.

COUNSEL

William J. Kilberg, Washington, D.C., for the plaintiffs-appellees.

Patti S. Kitching, Los Angeles, California, for the defendants-appellants.

Benjamin W. Boley, James R. Bieke, William R. Hanlon, Washington, D.C., for the amicus curiae.

OPINION

KENNEDY, Circuit Judge:

Appellants, the California State Board of Equalization, board members, and various state officials, appeal the district court's grant of summary judgment in favor of appellees, General Motors Corporation and the American National Red Cross. We reverse.

Appellees are fiduciaries of "employee welfare benefit plans" within the meaning of section 3(1) of the Employee Retirement Income and Security Act of 1974 (ERISA), 29 U.S.C. § 1002(1) (1982). They fund the plans, which provide disability and health care benefits, with company assets and excess-risk policies from Metropolitan Life Insurance Company. Under these policies, appellees are responsible for paying all claims up to a trigger point, an aggregate level of claims specified annually, while Metropolitan is responsible for paying all claims above that point.

Appellees adopted the excess risk policies to replace traditional policies under which Metropolitan received larger premiums and paid all claims. It appears that appellees did so to retain use of their funds until claims were actually paid and to reduce premiums tax liability for their insurer.

Appellants administer a tax on "gross premiums ... received" by insurance companies doing business in California. Cal. Const. art. XIII, § 28(c); Cal. Rev. & Tax Code

§§ 12201, 12221 (West 1970 & Supp. 1986). In calculating "gross premiums . . . received" by Metropolitan, appellants included premiums appellees paid Metropolitan plus benefits appellees paid employees under their plans. As a matter of state law, the California Supreme Court upheld this method of calculation in *Metropolitan Life Ins. Co. v. State Bd. of Equalization*, 32 Cal. 3d 649, 652 P.2d 426, 186 Cal. Rptr. 578 (1982).

Appellees' insurance contracts require them to reimburse Metropolitan for premium taxes incurred as a result of their plans. After learning of the California Supreme Court decision, they brought the instant action in federal court, seeking declaratory and injunctive relief. They argued that appellants' interpretation of "gross premiums . . . received," though valid as a matter of state law, was preempted by ERISA.[1] The district court granted appellees' motion for summary judgment. It enjoined appellants from calculating "gross premiums . . . received" with reference to benefits paid by the plans. *General Motors Corp. v. California State Bd. of Equalization*, 600 F. Supp. 76 (C.D. Cal. 1984) (original opinion, amended in unpublished order). This appeal followed.

Ultimately, we must determine whether ERISA preempts a premiums tax assessed against an insurer and calculated with reference to benefits paid by ERISA plans. Before we reach that issue, however, we must resolve various procedural challenges.

We first consider whether appellees have standing to bring this action. In order to satisfy the requirements for standing, appellees must allege injury that is "distinct and palpable," *Warth v. Seldin*, 422 U.S. 490, 501 (1975), and not "abstract," "conjectural," or "hypothetical," *City of Los Angeles v. Lyons*,

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[1]The preemption issue played no part in the California Supreme Court case because that case involved the taxable years 1967-69 and ERISA was not enacted until 1974.

461 U.S. 95, 101-02 (1983). The injury must be "fairly traceable to the defendant's allegedly unlawful conduct and likely to be redressed by the requested relief." *Allen v. Wright*, 468 U.S. 737, 751 (1984).

[1] Appellees satisfy these requirements. As a result of the taxation they allege to be unlawful, and their contract with Metropolitan, appellees will have to pay the insurance company substantial sums for which they would otherwise not be liable. Such real economic injuries have long been recognized as sufficient basis for standing. *See Sierra Club v. Morton*, 405 U.S. 727, 733 (1972). In addition, their injury is directly attributable to appellants' allegedly unlawful taxation, and would be fully redressed were the taxation enjoined. *See Wright*, 468 U.S. at 757-58 (discussing "fairly traceable" component of standing requirement); *Simon v. Eastern Kentucky Welfare Rights Org.*, 426 U.S. 26, 45-46 (1976) (discussing "redressibility" component of standing requirement).

This is not a case, moreover, in which appellees seek to assert rights of Metropolitan rather than rights of their own. They do not bring this action as bystanders affected by alleged violations of Metropolitan's rights, but as fiduciaries of employee benefit plans, who seek to vindicate rights ERISA grants in express terms.[2]

[2] The cases on which appellants rely to show that standing is lacking are readily distinguishable. In those cases, either an allegation that the plaintiff's own rights have been violated or an express grant of standing is absent. In *EMI Ltd. v. Bennett*, 738 F.2d 994 (9th Cir.) (*EMI II*), *cert. denied*, 469 U.S. 1073 (1984), we dismissed a parent corporation's action because the parent alleged injury flowing from violations of its subsid-

[2]These rights are contained in section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3) (1982), which allows fiduciaries to bring a civil action to enjoin violations of the Act's provisions, including the preemption provisions at issue.

iary's rights, not its own. *Id.* at 996-98. *Cf. Alcan Aluminum, Ltd. v. Dep't of Revenue*, 724 F.2d 1294, 1299 (7th Cir. 1984) (standing exists where parent alleges violation of its own rights). And in *Fentron Indus. v. Nat'l Shopmen Pension Fund*, 674 F.2d 1300 (9th Cir. 1982), we questioned an employer's standing because ERISA does not expressly grant employers the right to sue. *Id.* at 1305 n.5. In the case before us, in which both the appropriate allegation and the express grant are present, appellees have standing to proceed with their suit.

We next consider whether the Tax Injunction Act bars this action. The Tax Injunction Act, 28 U.S.C. § 1341 (1982), provides that "district courts shall not enjoin, suspend or restrain the assessment, levy or collection of any tax under state law where a plain, speedy and efficient remedy may be had in the courts of such state." *Id.* To obtain the relief they seek, therefore, appellees must show that their suit is not covered by this prohibition.

Appellees cannot maintain that ERISA is an exception to the Tax Injunction Act. The Supreme Court left that issue open in *Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 20 & n.21 (1983), but we resolved it in *Ashton v. Cory*, 780 F.2d 816, 821-22 (9th Cir. 1986), which holds that ERISA actions are subject to the Tax Injunction Act.

[3] In this case, however, the Tax Injunction Act is inapplicable by its own terms. The Act applies only when a party has a "plain, speedy and efficient" remedy in state court. As appellants concede, appellees have no remedy in state court. Under California law, only the party against whom a tax is assessed, in this case Metropolitan, may challenge the tax. Cal. Const. art. XIII, § 32; Cal. Rev. & Tax Code §§ 13101, 13108 (West 1970 & Supp. 1986).

Appellants' contention that Metropolitan's ability to challenge the tax constitutes a "plain, speedy and efficient" rem-

edy for appellees is unpersuasive. It is true that Metropolitan's interests are substantially similar to that of the appellees. *Capitol Industries-EMI, Inc. v. Bennett*, 681 F.2d 1107 (9th Cir.) (*EMI I*), *cert. denied*, 459 U.S. 1087 (1982), squarely holds, however, that a party without state administrative or judicial remedies can maintain a federal action even if a taxpayer with substantially the same interests has state remedies. *Id.* at 1119. The Tax Injunction Act is no bar to appellees' suit.

[4] We next consider whether abstention would be proper in this case. The preemption issue is one of federal law, *Marshall v. Chase Manhattan Bank, N.A.*, 558 F.2d 680, 683 (2d Cir. 1977), and the suit by appellees is one over which the federal courts exercise exclusive jurisdiction, 29 U.S.C. § 1132(e)(1)). Under these circumstances, abstention would be inappropriate. *See Colorado River Water Conservation Dist. v. United States*, 424 U.S. 800, 813-20 (1976) (discussing circumstances where abstention is appropriate); *Silberkleit v. Kantrowitz*, 713 F.2d 433, 436 (9th Cir. 1983) (declining to abstain where "exclusively federal claims" are present).

[5] We last consider whether the eleventh amendment precludes an award of injunctive relief in this case. The eleventh amendment does not bar actions for injunctive relief against individual state officials, but it does bar such actions against the state or its agencies, absent their consent. *Alabama v. Pugh*, 438 U.S. 781 (1978) (per curiam). As to the individual appellants, therefore, the district court's injunction may be permissible; but as to appellant Board, a state agency, the injunction must be vacated and the case dismissed. *See V.O. Motors, Inc. v. California State Bd. of Equalization*, 691 F.2d 871 (9th Cir. 1982) (dismissing suit for injunctive relief against appellant Board on eleventh amendment grounds).

[6] Having resolved the procedural matters before us, we address the merits of the case. We must determine whether ERISA preempts a premiums tax assessed against an insurer

and calculated with reference to benefits paid by ERISA plans. The district court held that ERISA preempted such a tax. *General Motors*, 600 F. Supp. at 80. We review that holding de novo, *United States v. McConney*, 728 F.2d 1195, 1201 (9th Cir.) (en banc), *cert. denied*, 469 U.S. 824 (1984), and reverse.

The framework for analysis of ERISA preemption claims is well established. *See, e.g., Moore v. Provident Life & Accident Ins. Co.*, 786 F.2d 922, 926 (9th Cir. 1986). The first step in the analysis is to determine whether the state law at issue "relate[s] to" employee benefit plans, thereby invoking ERISA's preemption clause, 29 U.S.C. § 1144(a). *Moore*, 786 F.2d at 926.

[7] The Supreme Court has repeatedly emphasized the broad scope of the preemption clause. *Metropolitan Life Ins. Co. v. Massachusetts*, 105 S. Ct. 2380, 2389 (1985); *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 97 (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981). In its most recent pronouncement on the subject, the Court stated that the phrase "relate[s] to" is to be given "its broad common-sense meaning, such that a state law 'relate[s] to' a benefit plan 'in the normal sense of the phrase, if it has a connection with or reference to such a plan.' " *Metropolitan*, 105 S. Ct. at 2389 (quoting *Shaw*, 463 U.S. at 97).

The Court's broad reading of the preemption clause leads us to conclude that the tax at issue "relate[s] to" benefit plans. The tax is computed on the basis of benefits paid by the plans; reference to plan activities in computing the tax is unavoidable. In its broadest sense, therefore, ERISA applies, and further analysis is required.

[8] We recognize that the preemption clause is not all encompassing, *Martori Bros. Distrib. v. James-Massengale*, 781 F.2d 1349, 1356 (9th Cir. 1986), and that state laws may affect benefit plans in "too tenuous, remote, or peripheral a

manner" to justify preemption, *Shaw*, 463 U.S. at 100 n.21. Nevertheless, we conclude that the explicit use of plan payments in calculating the tax satisfies the modest requirements for bringing the clause into play. *Cf. Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550 (6th Cir. 1987) (municipal income tax, applied without reference to plans, does not invoke preemption clause).

We also recognize that "governmental plans," as defined in ERISA, are not entitled to the protection of the preemption clause. 29 U.S.C. § 1003(b)(1) (1982). The Pension Benefit Guaranty Corporation (PBGC), however, has ruled that the Red Cross plan is not excluded from coverage as a "governmental plan." The conclusions of the PBGC are entitled to "great deference," *Connolly v. Pension Benefit Guar. Corp.*, 581 F.2d 729, 730 (9th Cir. 1978), *cert. denied*, 440 U.S. 935 (1979), and its rulings must stand unless there are "compelling indications" that they are incorrect, *Paden v. United States Dep't of Labor*, 562 F.2d 470, 473 (7th Cir. 1977). No such indications are present here, leading us to conclude that the Red Cross plan is entitled to the protection of the preemption clause.

[9] The second step in the preemption analysis involves the insurance saving clause, which provides that any state law that "regulates insurance, banking, or securities" shall remain in force. 29 U.S.C. § 1144(b)(2)(a). This clause must be construed broadly, with due regard for the states' traditional powers in the field of insurance. *Metropolitan*, 105 S. Ct. at 2389. Such a construction will undoubtedly return to the states much of the authority the preemption clause has taken away, but that result follows from the statutory language, which we are bound to apply. *See id.*

[10] The saving clause must also be construed to cover taxation of insurance. The clause preserves the McCarran-Ferguson Act's reservation of the business of insurance to the states. *Metropolitan*, 105 S. Ct. at 2392 n.21. McCarran-

Ferguson, in turn, preserves the states' ability to "tax and regulate" insurance. *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 218 (1979). Thus taxation of insurance, no less than regulation, may fall within the saving clause.

[11] Given this background, we hold that the saving clause preserves the tax at issue, for the tax is intimately associated with the business of insurance. It is imposed on insurers, as a result of their participation in the insurance business in California. And it is calculated in terms of premiums, the traditional mode of payment for insurance services.

[12] Concededly, the tax is calculated with reference to benefit payments. The payments, however, are used only as a means of capturing the total cost of the insurance provided, the amount which appellants' premiums tax seeks to reach. *Metropolitan Life Ins. Co. v. State Bd. of Equalization*, 32 Cal. 3d 649, 660, 652 P.2d 426, 186 Cal. Rptr. 578 (1982). Total cost has two elements, the net premium and the loading. The net premium is the amount which, invested properly, will yield a fund sufficient to pay expected claims. The loading is the amount added to the net premium to cover the insurer's administrative costs and compensate it for assuming the risk that claims will exceed expected levels. *Allstate Ins. Co. v. State Bd. of Equalization*, 169 Cal. App. 2d 165, 168, 336 P.2d 961, 964 (1959). Under a traditional policy, both elements are included in the premium paid the insurer, making that premium an accurate measure of the total cost of the insurance provided.

Here, the premium paid the insurer includes only the loading element, so a method for determining the dollar amount of the net premium element is necessary. As the benefits paid by the plans equal the net premium under a traditional policy, appellants have referred to those payments in calculating the tax. This reference, which is used to measure the cost of insurance provided accurately, does not deprive the tax of the pro-

tection of the saving clause, for the incidence of the tax remains on the insurer, not the plans.

Elevating the incidence of the tax over the effects may be somewhat formalistic. It is, nevertheless, a familiar method of analysis in the field of taxation. *See Flint v. Stone Tracy Co.*, 220 U.S. 107 (1911) (tax on corporate franchise valid even though effect is to reach income exempt from taxation). Perhaps more importantly, it is the method *Metropolitan* requires us to employ in cases of this sort.

[13] The final step in the preemption analysis requires consideration of the deemer clause, which provides that no benefit plan "shall be deemed to be an insurance company . . . or to be engaged in the business of insurance . . . for purposes of any law of any state purporting to regulate insurance companies . . . ." 29 U.S.C. § 1144(b)(2)(B) (1982). The precise scope of this clause remains unclear. At base, however, it appears to prevent states from regulating benefit plans simply because they provide insurance for covered employees. *See Wadsworth v. Whaland*, 562 F.2d 70, 77 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978); *Eversole v. Metropolitan Life Ins. Co.*, 500 F. Supp. 1162, 1169 (C.D. Cal. 1980).

[14] The tax at issue does not run afoul of the deemer clause. It is imposed on insurance companies, not benefit plans. It may affect benefit plans, but effects are not determinative. *Metropolitan* so holds. *Metropolitan* left intact a mandated-benefit law that had significant effects on Massachusetts plans. In so doing, it indicated that state laws affecting benefit plans may escape preemption if they fall directly on insurance companies, as the tax at issue does.

Moore v. Provident Life & Accident Ins. Co., 786 F.2d 922 (9th Cir. 1986), and *United Food and Commercial Workers v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986), are not to the contrary. Both involve insurance policies similar to those in the case before us. However, both also find the saving clause

inapplicable, presumably because insurance is not involved in any meaningful sense in either case. *Moore*, 786 F.2d at 927; *Pacyga*, 801 F.2d at 1159. Here, in contrast, the saving clause is fully applicable, leaving the tax in force.

REVERSED.

APPENDIX C

UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA

GENERAL MOTORS CORPORATION, *et al.*,

Plaintiffs,

v.

CALIFORNIA STATE BOARD OF EQUALIZATION, *et al.*,

Defendants.

No. CV 83-6801-DWW(KX)

Employee benefit plan fiduciaries brought action against California State Board of Equalization and others for declaratory, injunctive, and remedial relief in connection with insurance franchise taxes imposed. Defendants moved for judgment on the pleadings. The District Court, David W. Williams, Senior District Judge, held that: (1) to extent that state had in fact imposed insurance franchise taxes against employee benefit plan excess risk insurer based on gross premiums, fiduciaries of those plans had standing under ERISA to challenge the action; (2) ERISA is outside scope of prohibition against construing any federal law so as to impair or invalidate state law regulating insurance; and (3) by imposing an insurance franchise tax on gross premiums received by excess risk insurers in connection with employee benefit plan fiduciaries' retention of responsibility for payment of all benefits from the respective plans below a trigger point, state indirectly taxed those benefit payments and impeded the fiduciaries' funding discretion, in violation of ERISA preemption.

Motion granted in part and denied in part.

Stephen E. Tallent, Wayne A. Schrader, Gibson, Dunn & Crutcher, Los Angeles, Cal., for plaintiffs; William J. Kilberg, Paul D. Inman, Gibson, Dunn & Crutcher, Washington, D.C., of counsel.

John K. Van de Kamp, Atty. Gen. of the State of Cal., Edmond B. Mamer, Patti S. Kitching, Deputy Attys. Gen., Los Angeles, Cal., for defendants.

ORDER

DAVID W. WILLIAMS, Senior District Judge.

Plaintiffs, General Motors Corporation ("GMC") and the American National Red Cross ("Red Cross"), in their capacities as sponsoring employers and administrators of certain employee disability and health care plans established pursuant to collective bargaining agreements, and current trustees of the Motion Picture Health and Welfare Fund (MPF"), are suing defendants, The California State Board of Equalization ("Board"), Board members, and certain state officials, for declaratory, injunctive, and remedial relief.

Both GMC and Red Cross entered into excess risk arrangements with the Metropolitan Life Insurance Company ("Metropolitan") providing that they would remain responsible for payments of all benefits from their respective plans below a trigger point. This trigger point was to be established annually based on a projected level of aggregate benefit payments. Local GMC units were to maintain claim records and evaluate and pay claims below the trigger amount for sickness and accident coverage. Metropolitan would perform these functions for other forms of coverage. The funds used to pay the pretrigger claims are

drawn from GMC accounts. Similarly, the funds used to pay pretrigger claims for Red Cross are drawn by Metropolitan from a Red Cross account, and Metropolitan is authorized to draw on that account only to satisfy pretrigger claims.

Defendants levied taxes upon Metropolitan on benefits paid out of the GMC Disability Trusts, the GMC Plan, and the Red Cross Plan. As Metropolitan was indemnified by GMC and Red Cross for the tax payments, these costs were passed onto them.

The MPF entered into an excess risk arrangement with the Union Labor Life Insurance Company ("Union Labor") whereby MPF assumed the risk of paying benefits up to a defined trigger point. A year or so later the trustees of the fund resolved to terminate their excess risk policies and become completely self-insured with respect to those components covered by it. MPF now believes defendants will levy a tax on benefits paid out during the year in which the excess risk arrangement was in existence. It too has an existing indemnity agreement, so the MPF assumes it will incur the cost for the tax.

Plaintiffs bring this action because defendants' interpretation of "gross premiums" was upheld by the California Supreme Court in *Metropolitan Life Ins. Co. v. State Board of Equalization,* 32 Cal.3d 649, 186 Cal.Rptr. 578, 652 P.2d 426 (1982). In that action, for the years 1967–1969 Metropolitan was assessed an insurance franchise tax based upon the amount of Metropolitan's gross premiums. The Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.,* was not at issue then, however, because the years involved were prior to ERISA's passage in 1974. Metropolitan has now raised that issue, and it has filed refund claims for the 1975–1982 years alleging that the franchise tax has been preempted by ERISA. These claims were denied, and Metropolitan has filed suit in San Francisco Superior Court.

The predominant legal issues raised in this action are this court's jurisdiction, the plaintiffs' standing to sue, the State of California's power to tax in the manner at issue here, and ERISA's possible preemptive effect. The courts have favored a broad interpretation of ERISA's preemptive provision. State taxation is not one of the enumerated exceptions to ERISA's preemptive reach. A recent ERISA amendment and relevant legislative history also indicate Congress' intent to preempt any state tax law which relates to employee benefit plans. Defendants' characterization of "gross premiums" in this context runs afoul of ERISA. Therefore, this court must rule that defendants' tax practice as described in this action is preempted by ERISA.

JURISDICTION AND STANDING

Jurisdiction is conferred upon this court through ERISA, 29 U.S.C. § 1132(a)(3) and (4). Plaintiffs are fiduciaries of employee welfare benefit plans. As such, they have a direct and explicit statutory basis for standing. Section 1132(a)(3) provides that a fiduciary may bring a civil action to enjoin any act or practice which violates any provisions of a plan's terms. A participant or beneficiary may bring an action to recover benefits under the terms of his plan in state court. Furthermore, defendants' interpretation of "gross premiums" and their assessment and collection orders based upon such an interpretation are "state action having effect of law." So, they are state laws within the meaning of ERISA's section 1144(c)(1).

Defendants contend that any injury suffered by plaintiffs results solely from plaintiffs' agreement with an insurance company to reimburse it for its tax payments. They cite *EMI Ltd. v. Bennett,* 738 F.2d 994 (9th Cir.1984) and *Shell Petroleum, N.V. v. Graves,* 709 F.2d 593 (9th Cir.1983) for the proposition that a third party who is not being taxed does not have standing to sue the taxing authority because his injury is neither direct, individual, distinct, nor

palpable. *See also Allen v. Wright,* — U.S. —, 104 S.Ct. 3315, 82 L.Ed.2d 556 (1984). Plaintiffs' jurisdictional and standing foundation, however, arises under ERISA provisions as they bring this action as plan fiduciaries seeking to preempt a practice that relates to their employee benefit plans. ERISA expressly empowers fiduciaries to seek relief in federal court against "any act or practice" which violates ERISA's provisions. 29 U.S.C. § 1132(a)(3) and (f).

Although MPF is also a fiduciary under ERISA, no indication has been given that defendants' actions have had an adverse effect upon its employee benefit plan. Unlike GMC and Red Cross, there is no tax deficiency to speak of which has been asserted against Union Labor, MPF's insurer. MPF can assert ERISA in defense of actions affecting its plan, but it cannot be allowed to do so when the alleged effect is speculative, too remote, or too tenuous.

Therefore, this action is dismissed on the independent grounds of lack of subject matter jurisdiction and lack of standing as to plaintiff MPF, but not as to plaintiffs GMC and Red Cross.

THE STATES' AUTHORITY TO TAX

Defendants contend that the Tax Injunction Act, 28 U.S.C. § 1341, precludes plaintiffs' request for this court to enjoin the assessment and/or collection of a tax. That provision does hold that the district court shall not interfere with the assessment, levy, or collection of any tax under state law where a plain, speedy, and efficient remedy may be had in state court.

The McCarran-Ferguson Act, 15 U.S.C. § 1011, *et seq.*, provides that the regulation and taxation of the business of insurance shall be subject to state law, and any state law effecting this purpose shall not be impaired unless a federal act specifically relates to the business of insurance.

Defendants in this action are plan fiduciaries, and the tax has not been levied directly upon them. Therefore, a state court remedy may not be available to them; but, ERISA does allow these defendants to bring an action in federal court. ERISA broadly preempts "any and all" state laws which relate to any employee benefit plan. 29 U.S.C. § 1144(a). Furthermore, in *Hewlett-Packard Co. v. Barnes,* 571 F.2d 502, 505 (9th Cir.) *cert. denied,* 439 U.S. 831, 99 S.Ct. 108, 58 L.Ed.2d 125 (1978) the Ninth Circuit determined that where the McCarran-Ferguson Act applies ERISA falls within the clause excepting federal laws that "specifically relate" to the business of insurance. The court recognized the policy of reserving to the states the power to regulate insurance unless an Act such as ERISA specifically relates to it. It then determined that ERISA was such an excepting Act. Therefore, ERISA was removed from the scope of prohibition against construing any federal law so as to impair or invalidate state law regulating insurance.

ERISA's PREEMPTIVE EFFECT

Two cases which discussed the relationship of state tax provisions to ERISA's preemption mandate are not Ninth Circuit cases, but they relate important legislative history relevant to the instant action. *Northwest Airlines, Inc. v. Roemer,* 603 F.Supp. 7, Empl. Benefit Cas. 1307 (BNA) (D.C.Minn.1984) held that ERISA preempts states' authority to levy a state income tax on ERISA-covered pension plans since the statutory language and legislative history indicated a congressional intent to preempt state tax laws as they relate to employee benefit plans. *National Carriers' Conf. Comm. v. Heffernan,* 454 F.Supp. 914 (D.C.Conn.1978) stated that a tax imposed upon an employee welfare benefit plan was void and unenforceable insofar as it applied to such plans covered by ERISA.

The *Northwest Airlines* defendant argued for a narrow construction of section 1144(a) contending that state law

"relates to" an employee benefit plan only if it regulates the terms and conditions of the plan. The court noted that such a narrow reading was rejected by the Supreme Court in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 101 S.Ct. 1895, 68 L.Ed.2d 402 (1981). There, the Court held that ERISA makes clear that even indirect state action bearing upon private pensions may encroach upon the area of exclusive federal concern. Similarly, in *Shaw v. Delta Airlines*, 463 U.S. 85, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983) the Supreme Court carefully reviewed the legislative history of ERISA and concluded that Congress intended the words "relate to" to be construed in a "broad sense." The *Shaw* Court then held that ERISA preempts any law that has a connection with or reference to any employee benefit plan unless it falls within one of the exceptions—state laws regulating insurance, banking, or securities, or state criminal laws.

In *National Carriers'* the fiduciaries of an employee benefit plan sought injunctive and declaratory relief from the assessment and collection of a Connecticut tax on the plan. The court reasoned that the phrase "any and all" plainly indicated an intention to reach every state statute that fits the description of "relating to" an employee benefit plan. 454 F.Supp. at 915.

As the *Northwest Airlines* court acknowledged, any contention that ERISA preemption should be narrowly construed is undermined by Congress' specific identification of state legislation areas which were to be excepted from ERISA's preemption provision. When ERISA was originally considered, Congress rejected a request by the Secretaries of Labor and Treasury to exempt state taxation from preemption. In 1983, when ERISA's preemption language was amended to exclude Hawaii's experimental health benefit statute from ERISA's preemption provision, Congress specifically endorsed the preemption of state tax laws. That amendment added section 1144(b)(5)(B)(i) which reads in part:

> Nothing in subparagraph (A) shall be construed to exempt from subsection (a) [§ 1144(a)]—any State tax law relating to employee benefit plans . . . .

In the Conference Report which discussed this particular amendment, it was stated that

> [t]he provision generally exempts the Hawaii Prepaid Health Care Act from preemption by ERISA. Under the provision, however, preemption is continued with respect to . . . any State tax law relating to employee benefit plans . . . .
> H.R.Rep. No. 97-984, 97th Cong., 2d Sess. 18 (1982), U.S.Code Cong. & Admin. News, pp. 4580, 4603.

In addition, the legislative history of "Tax and ERISA Provisions," as related in 1982 U.S.Code Congressional and Administrative News at pages 4595-96, gives some indication of Congress' intent. It states:

> Also, the provision [the amendment] does not affect the status, under the preemption provisions of ERISA, of any state tax law relating to employee benefit plans.

These excerpts convey the impression that section 1144(b)(5)(B)(i) was directed to all state tax laws and was not just in response to Hawaii's plan.

The gravamen of ERISA's preemption thrust derives from some determination as to how the challenged law relates to the ERISA plan. Defendants characterize the gross premium tax as an assessment against Metropolitan for doing business in California. Yet, in fact, it is the amount which is paid out by the plaintiffs below the trigger point which is being treated as a premium received by Metropolitan and is being taxed. Under ERISA this taxation practice is preempted because it "relates to" or bears some connection or reference to the plans by using the plans' payments as a means of measuring taxable premiums. The defendants are indirectly taxing benefit pay-

ments and they are impeding the discretion of plan sponsors to fund their plan guarantees through a combination of general assets and excess risk insurance.

This court recognizes the important state interests which are involved in this action, and balances that consideration in its ruling. The strong congressional intent, however, to preempt those actions which affect ERISA plans directs this court to find that ERISA prevents the taxation practice which has taken place here.

It is ordered, therefore, that defendants motion for judgment on the pleadings be denied as to plaintiffs GMC and Red Cross, but granted as to Plaintiff MPF because it lacks standing. It is further ordered that defendants and their agents refrain from taxing plaintiffs' and other insurance companies based on their interpretation of "gross premiums," which includes in the amount subject to tax benefit payments from employee benefit plans to their participants.

SO ORDERED.

APPENDIX D

UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA

GENERAL MOTORS CORPORATION, *et al.*,

Plaintiffs,

v.

CALIFORNIA STATE BOARD OF EQUALIZATION, *et al.*,

Defendants.

No. CV 83-6801-DWW (KX)

Fiduciaries of employee benefit plans brought action seeking declaratory, injunctive and remedial relief against taxation of employer payments under certain disability and health care plans, alleging taxes were preempted by ERISA. The District Court, David W. Williams, Senior District Judge, in an amended order, held that: (1) fiduciary whose insurer had not been assessed a tax deficiency lacked standing; (2) injunctive relief was not precluded by the Tax Injunction Act; and (3) tax was preempted by ERISA.

Judgment accordingly.

See also 600 F.Supp. 76.

AMENDED ORDER DENYING DEFENDANT'S MOTION FOR JUDGMENT ON THE PLEADINGS AND GRANTING PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

DAVID W. WILLIAMS, Senior District Judge.

Plaintiffs, General Motors Corporation ("GMC") and the American National Red Cross ("Red Cross"), in their ca-

pacities as sponsoring employers and administrators of certain employee disability and health care plans established pursuant to collective bargaining agreements, and current trustees of the Motion Picture Health and Welfare Fund ("MPF"), are suing defendants, The California State Board of Equalization ("Board"), Board members, and certain state officials, for declaratory, injunctive, and remedial relief.

Both GMC and Red Cross entered into excess risk arrangements with the Metropolitan Life Insurance Company ("Metropolitan") providing that they would remain responsible for payments of all benefits from their respective plans below a trigger point. This trigger point was to be established annually based on a projected level of aggregate benefit payments. Local GMC units were to maintain claim records and evaluate and pay claims below the trigger amount for sickness and accident coverage. Metropolitan would perform these functions for other forms of coverage. The funds used to pay the pretrigger claims are drawn from GMC accounts. Similarly, the funds used to pay pretrigger claims for Red Cross are drawn by Metropolitan from a Red Cross account, and Metropolitan is authorized to draw on that account only to satisfy pretrigger claims.

Defendants levied taxes upon Metropolitan on benefits paid out of the GMC Disability Trusts, the GMC Plan, and the Red Cross Plan. As Metropolitan was indemnified by GMC and Red Cross for the tax payments, these costs were passed onto them.

The MPF entered into an excess risk arrangement with the Union Labor Life Insurance Company ("Union Labor") whereby MPF assumed the risk of paying benefits up to a defined trigger point. A year or so later the trustees of the fund resolved to terminate their excess risk policies and become completely self-insured with respect to those components covered by it. MPF now believes defendants

will levy a tax on benefits paid out during the year in which the excess risk arrangement was in existence. It too has an existing indemnity agreement, so the MPF assumes it will incur the cost for the tax.

Plaintiffs bring this action because defendants' interpretation of "gross premiums" was upheld by the California Supreme Court in *Metropolitan Life Ins. Co. v. State Board of Equalization,* 32 Cal.3d 649, 196 Cal.Rptr. 578, 652 P.2d (1982). In that action, for the years 1967–1969 Metropolitan was assessed an insurance franchise tax based upon the amount of Metropolitan's gross premiums. The Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.,* was not at issue then, however, because the years involved were prior to ERISA's passage in 1974. Metropolitan has now raised that issue, and it has filed refund claims for the 1975–1982 years alleging that the franchise tax has been preempted by ERISA. These claims were denied, and Metropolitan has filed suit in San Francisco Superior Court.

The predominant legal issues raised in this action involve this court's jurisdiction, the plaintiffs' standing to sue, the State of California's power to tax in the manner at issue here, and ERISA's possible preemptive effect. The courts have favored a broad interpretation of ERISA's preemption provision. State taxation is not one of the enumerated exceptions to ERISA's preemptive reach. A recent ERISA amendment and relevant legislative history also indicate Congress' intent to preempt any state tax law which relates to employee benefit plans. Defendants' characterization of "gross premiums" in this context runs afoul of ERISA. Therefore, this court must rule that defendants' tax practice as described in this action is preempted by ERISA.

JURISDICTION AND STANDING

Jurisdiction is conferred upon this court through ERISA, 29 U.S.C. § 1132(a)(3) and (4). Plaintiffs are fiduciaries of

employee welfare benefit plans. As such, they have a direct and explicit statutory basis for standing. Section 1132(a)(3) provides that a fiduciary may bring a civil action to enjoin any act or practice which violates any provisions of a plan's terms. A participant or beneficiary may bring an action to recover benefits under the terms of his plan in state court, but plan fiduciaries must bring their preemption cases exclusively in federal court. Furthermore, defendants' interpretation of "gross premiums" and their assessment and collection orders based upon such an interpretation are "state action having effect of law." So, they are state laws within the meaning of ERISA's section 1144(c)(1).

Defendants contend that any injury suffered by plaintiffs results solely from plaintiffs' agreement with an insurance company to reimburse it for its tax payments. They cite *EMI Ltd. v. Bennett,* 738 F.2d 994 (9th Cir.1984) and *Shell Petroleum, N.V. v. Graves,* 709 F.2d 593 (9th Cir.1983) for the proposition that a third party who is not being taxed does not have standing to sue the taxing authority because his injury is neither direct, individual, distinct, nor palpable. *See also Allen v. Wright,* 468 U.S. 737, 104 S.Ct. 3315, 82 L.Ed.2d. 556 (1984). Plaintiffs' jurisdictional and standing foundation, however, arises under ERISA provisions as they bring this action as plan fiduciaries seeking to preempt a practice that relates to their employee benefit plans. ERISA expressly empowers fiduciaries to seek relief in federal court against "any act or practice" which violates ERISA's provisions. 29 U.S.C. § 1132(a)(3) and (f).

Although MPF is also a fiduciary under ERISA, no indication has been given that defendants' actions have had an adverse effect upon its employee benefit plan. Unlike GMC and Red Cross, there is no tax deficiency to speak of which has been asserted against Union Labor, MPF's insurer. MPF can assert ERISA in defense of actions affecting its plan, but it cannot be allowed to do so when the alleged effect is speculative, too remote, or too tenuous.

Therefore, this action is dismissed on the independent grounds of lack of subject matter jurisdiction and lack of standing as to plaintiff MPF, but not as to plaintiffs GMC and Red Cross.

THE STATES' AUTHORITY TO TAX

Defendants contend that the Tax Injunction Act, 28 U.S.C. § 1341, precludes plaintiffs' request for this court to enjoin the assessment and/or collection of a tax. That provision does hold that the district court shall not interfere with the assessment, levy, or collection of any tax under state law where a plain, speedy, and efficient remedy may be had in state court.

The McCarran-Ferguson Act, 15 U.S.C. § 1011, *et seq.*, provides that the regulation and taxation of the business of insurance shall be subject to state law, and any state law effecting this purpose shall not be impaired unless a federal act specifically relates to the business of insurance.

Defendants in this action are plan fiduciaries, and the tax has not been levied directly upon them. Therefore, a state court remedy may not be available to them; but, ERISA does allow these defendants to bring an action in federal court. ERISA broadly preempts "any and all" state laws which relate to any employee benefit plan. 29 U.S.C. § 1144(a). Furthermore, in *Hewlett-Packard Co. v. Barnes,* 571 F.2d 502, 505 (9th Cir.), *cert. denied,* 439 U.S. 831, 99 S.Ct. 108, 59 L.Ed.2d 125 (1978) the Ninth Circuit determined that where the McCarran-Ferguson Act applies ERISA falls within the clause excepting federal laws that "specifically relate" to the business of insurance. The court recognized the policy of reserving to the states the power to regulate insurance unless an Act such as ERISA specifically relates to it. It then determined that ERISA was such an excepting Act. Therefore, ERISA was removed from the scope of prohibition against construing any fed-

eral law so as to impair or invalidate state law regulating insurance.

ERISA's PREEMPTIVE EFFECT

Two cases which discussed the relationship of state tax provisions to ERISA's preemption mandate are not Ninth Circuit cases, but they relate important legislative history relevant to the instant action. *Northwest Airlines, Inc. v. Roemer,* Empl. Benefit Cas. 1307 (BNA) (D.C.Minn.1984) held that ERISA preempts states' authority to levy a stgate income tax on ERISA-covered pension plans since the statutory language and legislative history indicated a congressional intent to preempt state tax laws as they relate to employee benefit plans. *National Carriers' Conf. Comm v. Heffernan,* 454 F.Supp. 914 (D.C.Conn. 1978) stated that a tax imposed upon an employee welfare benefit plan was void and unenforceable insofar as it applied to such plans covered by ERISA.

The *Northwest Airlines* defendant argued for a narrow construction of section 1144(a) contending that state law "relates to" an employee benefit plan only if it regulates the terms and conditions of the plan. The court noted that such a narrow reading was rejected by the Supreme Court in *Alessi v. Raybestos-Manhattan, Inc.,* 451 U.S. 504, 101 S.Ct. 1895, 68 L.Ed.2d 402 (1981). There, the Court held that ERISA makes clear that even indirect state action bearing upon private pensions may encroach upon the area of exclusive federal concern. Similarly, in *Shaw v. Delta Airlines,* 463 U.S. 85, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983) the Supreme Court carefully reviewed the legislative history of ERISA and concluded that Congress intended the words "relate to" to be construed in a "broad sense." The *Shaw* Court then held that ERISA preempts any law that has a connection with or reference to an employee benefit plan unless it falls within one of the exceptions—state laws regulating insurance, banking, or securities, or state criminal laws.

In *National Carriers'* the fiduciaries of an employee benefit plan sought injunctive and declaratory relief from the assessment and collection of a Connecticut tax on the plan. The court reasoned that the phrase "any and all" plainly indicated an intention to reach every state statute that fits the description of "relating to" an employee benefit plan. 454 F.Supp. at 915.

As the *Northwest Airlines* court acknowledged, any contention that ERISA preemption should be narrowly construed is undermined by Congress' specific identification of state legislation areas which were to be excepted from ERISA's preemption provision. When ERISA was originally considered, Congress rejected a request by the Secretaries of Labor and Treasury to exempt state taxation from preemption. In 1983, when ERISA's preemption language was amended to exclude Hawaii's experimental health benefit statute from ERISA's preemption provision, Congress specifically endorsed the preemption of state tax laws. That amendment added section 1144(b)(5)(5)(i) which reads in part:

> Nothing in subparagraph (A) shall be construed to exempt from subsection (a) [§ 1144(a)]—any State tax law relating to employee benefit plans . . . .

In the Conference Report which discussed this particular amendment, it was stated that

> [t]he provision generally exempts the Hawaii Prepaid Health Care Act from preemption by ERISA. Under the provision, however, preemption is continued with respect to . . . any State tax law relating to employee benefit plans . . .
> H.R.Rep. No. 97-984, 97th Cong., 2d Sess. 18 (1982), U.S.Code Cong. & Admin. News 1982, pp. 4580, 4603.

In addition, the legislative history of "Tax and ERISA Provisions," as related in 1982 U.S. Code Congressional

and Administrative News at pages 4595–96, gives some indication of Congress' intent. It states:

> Also, the provision [the amendment] does not affect the status, under the preemption provisions of ERISA, of any state tax law relating to employee benefit plans.

These excerpts convey the impression that section 1144(b)(5)(B)(i) was directed to all state tax laws and was not just in response to Hawaii's plan.

The gravamen of ERISA's preemption thrust derives from some determination as to how the challenged law relates to the ERISA plan. Defendants characterize the gross premium tax as an assessment against Metropolitan for doing business in California. Yet, in fact, it is the amount which is paid out by the plaintiffs below the trigger point which is being treated as a premium received by Metropolitan and is being taxed. Under ERISA this taxation practice is preempted because it "relates to" or bears some connection or reference to the plans by using the plans' payments as a means of measuring taxable premiums. The defendants are indirectly taxing benefit payments and they are impeding the discretion of plan sponsors to fund their plan guarantees through a combination of general assets and excess risk insurance.

This court recognizes the important state interests which are involved in this action, and balances that consideration in its ruling. The strong congressional intent, however, to preempt those actions which affect ERISA plans directs this court to find that ERISA prevents the taxation practice which has taken place here.

It is ordered, therefore, that defendants' motion for judgment on the pleadings be denied as to plaintiffs GMC and Red Cross, but granted as to plaintiff MPF because it lacks standing. Plaintiffs' motion for summary judgment is granted. It is further ordered that defendants and their agents, employees, successors, and all persons in concert

with them cease and refrain from taxing indirectly the employee benefit plans of plaintiffs GMC and Red Cross based upon defendants' interpretation of "gross premiums," which includes, in the amount subject to tax, benefit payments from employee benefit plans to their participants.

AMENDED JUDGMENT

On the basis of all the evidence before me, I hereby declare, adjudge, and decree that:

1. Plaintiffs are fiduciaries of employee welfare benefit plans covered by the Employee Retirement Income Security Act of 1974 ("ERISA").

2. Defendants are officials of the State of California responsible in different capacities for imposing a franchise tax on insurance companies doing business in the State.

3. The California Constitution provides for taxation of insurance companies based on the "gross premiums received" by the insurance companies. Cal. Const., Art. XIII, § 28.

4. Defendants include in the "gross-premiums" amount subject to tax benefit payments from employee benefit plans to their participants based on the fiction that these amounts are "received", by insurance companies offering excess-risk insurance contracts to plan sponsors of employee benefit plans.

5. This characterization of benefit payments as "premium" payments was endorsed by the California Supreme Court in *Metropolitan Life Insurance Company v. State Board of Equalization,* 32 Cal.3d, 649, 186 Cal.Rptr 578, 652 P.2d 426 (1982).

6. ERISA preempts all "State laws," including state tax laws, "insofar as they . . . relate to" employee benefit plans. In *Shaw v. Delta Airlines,* 463 U.S. 85, 103 S.Ct.

2890, 77 L.Ed.2d 490 (1983), the Supreme Court made clear that the "relate to" language must be construed broadly to preempt all "State laws" that have "some reference to or connection with" employee benefit plans. *Id.*, 103 S.Ct. at 2899-2900.

7. The taxing practice at issue in the *Metropolitan Life* case is a "State law" which "relates to" employee benefit plans because it measures the "gross premiums" subject to tax by reference to employee benefit plan payments to participants and beneficiaries. This reference to plans is preempted by ERISA, since it results in indirectly taxing benefit plans and impeding the discretion of plan sponsors to purchase excess-risk policies.

Accordingly, it is hereby ordered that defendants and their agents, employees, successors, and all persons in concert with them cease and refrain from taxing indirectly the employee benefit plans of plaintiffs General Motors Corporation and the American Red Cross based upon defendants' interpretation of "gross premiums," which includes, in the amount subject to tax, benefit payments from employee benefit plans to their participants.

The court adopts as its finding of fact and conclusions of law the order issued for this action dated February 4, 1985.

APPENDIX E

FOR PUBLICATION

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

GENERAL MOTORS CORPORATION; AMERICAN NATIONAL RED CROSS; JASPER BALLANCE; et al.,
Plaintiffs-Appellees,

v.

CALIFORNIA STATE BOARD OF EQUALIZATION; WILLIAM M. BENNET; CONWAY H. COLLIS; ERNEST J. DRONENBURG, JR.; RICHARD NEVINS; GRAY DAVIS*; and BRUCE BUNNER,
Defendants-Appellants.

No. 85-5618
D.C. No. CV-83-6801-DWW
ORDER

Filed August 14, 1987

Before: Anthony M. Kennedy, Otto R. Skopil, Jr. and Arthur L. Alarcon, Circuit Judges.

Appeal from the United States District Court for the Central District of California .

COUNSEL

William J. Kilberg, Washington, D.C., for the plaintiffs-appellees.

Patti S. Kitching, Los Angeles, California, for the defendants-appellants.

*Substituted for Kenneth Cory, pursuant to Fed. R. App. P. 43(c)(1).

Benjamin W. Boley, James R. Bieke, William R. Hanlon, Washington, D.C., for the amicus curiae.

ORDER

The decision of the Supreme Court in *Pilot Life Ins. Co. v. Dedeaux*, 107 S. Ct. 1549 (1987), does not alter the opinion's analysis. *Pilot Life* involves a state law of general application, one that directly conflicts with a substantive provision of ERISA. This case, in contrast, involves a state law directed specifically at the insurance industry, one that does not conflict with any of ERISA's substantive provisions. Accordingly, the analysis of *Metropolitan Life Ins. Co. v. Massachusetts*, 105 S. Ct. 2380 (1985), remains fully applicable.

The full court has been advised of the suggestion for en banc hearing, and no judge of the court has requested a vote on the suggestion for rehearing en banc. Fed. R. App. P. 35(b).

The petition for rehearing is denied, and the suggestion for a rehearing en banc is rejected.

APPENDIX F

SUPREME COURT OF CALIFORNIA

METROPOLITAN LIFE INSURANCE COMPANY,
Plaintiff and Respondent,

v.

STATE BOARD OF EQUALIZATION,
Defendant and Appellant.

S.F. No. 24306

Filed Oct. 28, 1982

Summary

After the State Board of Equalization rejected an insurer's claim for a tax refund, the insurer sued for a refund and obtained a judgment for the full amount requested. The insurer provided coverage for employee group medical benefit plans. Prior to 1967, employers financed the entire cost of such coverage through monthly premiums paid to the insurer, which paid a gross premiums tax on the total amount received pursuant to Cal. Const., art. XIII, § $14^4/_5$ (now § 28), and Rev. & Tax. Code, §§ 12201, 12221. Starting in 1967, the insurer offered a group medical insurance plan under which the employers were required to assume the obligation to pay all employee claims for benefits up to a "trigger-point" amount, defined as the actuarially predicted monthly average level of aggregate employee claims, and the insurer remained obligated to pay all claims in excess of that amount. Under this plan, the insurer retained control over many aspects of the administration of the plan. The insurer determined the amount of all benefits to be paid in satisfaction of em-

ployee claims, both above and below the trigger point, with the obligation to defend and the right to settle suits contesting rejection of claims. As to 13 of the 15 employers covered by the plan, the insurer actually paid claims from special accounts of the employers pursuant to authorization by the employers. Although the employers were primarily liable for payment of pretrigger-point claims, the obligations of the insurer were inextricably intertwined with those of the employers. If an employer failed to make funds available for the payment of the pretrigger-point claims in any month, the insurer remained obligated to cover the unpaid claims, subject to reimbursement from the delinquent employer. The California Insurance Commissioner levied a tax on the sum of the amounts employers paid to the insurer as premiums plus the aggregate yearly claims paid to employees by employers. The insurer paid the amount levied and sought a refund. (Superior Court of the City and County of San Francisco, No. 677543, Robert J. Drewes, Judge.)

The Supreme Court reversed. The court held that the employers acted as mere agents of the insurer for the collection of premiums and that the entire cost of the plan, including not only the amount paid directly to the insurer as a premium for coverage in excess of the trigger-point amount, but also the amount paid out of the employers' funds to satisfy employee claims, was taxable to the insurer as gross premiums under Cal. Const., art. XIII, § $14^4/_5$ (now § 28), and Rev. & Tax. Code, §§ 12201, 12221. (Opinion by Mosk, J., with Bird, C. J., Broussard, J., and Miller, J.,* concurring. Separate dissenting opinion by Kaus, J., with Reynoso, J., and Barry-Deal, J.,* concurring.)

Headnotes

Classified to California Digest of Official Reports, 3d Series

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* Assigned by the Chairperson of the Judicial Council.

(1) Insurance Contracts and Coverage § 1—Insurance—Definition.—The Legislature has defined insurance as "a contract whereby one undertakes to indemnify another against loss, damage, or liability arising from a contingent or unknown event." (Ins. Code, § 22.) Thus, insurance necessarily involves two elements: A risk of loss to which one party is subject and a shifting of that risk to another party; and distribution of risk among similarly situated persons.

(2a, 2b) Insurance Companies § 1—Taxation—Gross Premiums Tax—Amounts Includible in "Gross Premiums."—Under a group medical insurance plan which required employers to assume the obligation to pay all employee claims for benefits up to a "trigger-point" amount, defined as the actuarially predicted, monthly average level of aggregate employee claims, and required the insurer to pay all claims in excess of that amount, the entire cost of the plan, including not only the amount paid directly to the insurer as a premium for the coverage in excess of the trigger-point amount, but also the amount paid out of the employers' funds to satisfy employee claims, was taxable to the insurer as gross premiums under Cal. Const., art. XIII, § $14^4/_5$ (now § 28), and Rev. & Tax. Code, §§ 12201, 12221. Under the plan, the employers did not function as independent insurers; as a matter of law, they functioned only as agents of the insurer for collection of premiums. Accordingly, the "trigger-point" amount was analogous to the "net premium" under a standard group policy, and the amount paid directly to the insurer for costs of administration and to compensate the insurer for assuming the risk that claims experience might fluctuate above the expected level (or trigger-point) was analogous to the loading under a standard arrangement. Thus, the gross premium which was subjected to the gross premiums tax was composed of the sum of the actual pretrigger-point claims pay-

ments and the amount paid directly to the insurer as premiums.

[See **Cal.Jur.3d,** Franchise and in Lieu Taxes, § 24, **Am.Jur.2d,** State and Local Taxation, § 428 et seq.]

(3) **Insurance Companies § 1—Taxation—Gross Premiums Tax—Amounts Includible in "Gross Premiums."**—In determining what amounts are to be included within the meaning of the term "gross premiums" for purposes of the gross premiums tax imposed on insurers (Cal. Const., art. XIII, § $14^{4}/_{5}$ (now § 28); Rev. & Tax. Code, §§ 12201, 12221), the insurer is to be assessed a tax based on the total cost of the insurance coverage provided to the insured.

(4) **Insurance Contracts and Coverage § 20—Premiums Tax—Amounts Includible in "Gross Premiums."**—In determining what amounts are to be included within the meaning of the term "gross premiums" for purposes of the gross premiums tax imposed on insurers (Cal. Const., art. XIII, § $14^{4}/_{5}$ (now § 28); Rev. & Tax. Code, §§ 12201, 12221), the insurer is to be assessed a tax based on the total cost of the insurance coverage provided to the insured.

(4) **Insurance Contracts and Coverage § 20—Premiums—Gross Premium, Net Premium, Loading—Definitions.**—The gross premium, or the amount charged in a contract of insurance, ordinarily includes two elements, that is, the net premium and the loading. The loading, or the amount arbitrarily added to the net premium is intended to cover the expenses of the company. The net premium under standard group policies is the expected level of claims payment. The loading ordinarily is composed of miscellaneous charges, including administrative costs of the insurer, a charge for assuming the risk that claims outlays will exceed the expected level, and an element of profit or dividends.

(5) **Insurance Companies § 1—Taxation—Gross Premiums Taxes.**—The tax liability of an insurer should not depend on the bare formality of whether the employer pays the cost of benefits out of his own pocket or negotiates a pay raise with his employees, then deducts the costs of the plan from their salaries and forwards those amounts to the insurer. In both situations, the insurer obtains the same benefit of doing insurance business in this state. Accordingly, the entire cost of an employee benefit plan, whether paid from the employer's funds or financed by deductions from the salaries of employees, is taxable as gross premiums inuring to the benefit of the insurer.

Counsel

George Deukmejian, Attorney General, and Timothy G. Laddish, Deputy Attorney General, for Defendant and Appellant.

Hart H. Spiegel, Robert S. Daggett, Donald J. Heng, Jr., Brobeck, Phleger & Harrison and Gerard J. Talbot for Plaintiff and Respondent.

Opinion

MOSK, J.—The California Constitution imposes a franchise tax "on each insurer doing business in this state," measured by the amount of "gross premiums" which the insurer receives in a particular year. (Cal. Const., art. XIII, § 28 (formerly § 14⁴/₅); see also Rev. & Tax. Code, §§ 12201, 12221.) We must decide whether certain amounts, though never formally paid to Metropolitan Life Insurance Company (Metropolitan), nevertheless are to be included within the gross premiums measure of the tax imposed on its business done in California.

Metropolitan writes coverage for employee group medical benefit plans. Prior to 1967, employers financed the entire cost of such coverage through monthly premiums

paid to Metropolitan, which paid a premiums tax on the total amount received. With respect to the benefit plans for 15 large employers, however, Metropolitan has devised a new arrangement in which it claims to have shifted 90 percent of the obligation for medical benefit coverage to the employers and thereby reduced by 90 percent the gross premiums received from those employers, reducing its premiums tax liability accordingly. Because we conclude that under the new arrangement the employer is a mere agent of Metropolitan for collection of premiums, not an independent insurer, we attribute the entire cost of the group plan to Metropolitan's gross premiums and reverse the trial court's judgment granting a tax refund to Metropolitan.

Before 1967, when it began offering the "Mini-Met" plan which is the subject of the instant controversy, Metropolitan offered employers a plan denominated the standard group policy. According to the terms of such policies, the employers paid a premium in return for Metropolitan's assumption of the entire obligation to provide health coverage to benefitted employees. The premiums for the standard policies represented the entire cost of the agreed-upon coverage, and Metropolitan paid a tax calculated as a percentage of the total premiums it received.

The arrangements here at issue represent an alteration of Metropolitan's standard group policies. Under the standard plans, Metropolitan retained the benefit of the "float"—the use of premium funds from the time of payment until the funds were disbursed to satisfy claims. In addition, Metropolitan apparently passed through to the employers, as an element of premiums, the amount of its premiums tax liability. Motivated by the desire to reduce the cost of insurance coverage and to obtain an improved cash-flow situation, the employers persuaded Metropolitan to modify its group insurance coverage. Metropolitan obliged by developing the Mimi-Met rider to the standard group policy. The rider shifted certain cash-flow advantages to the em-

ployers and sought to substantially reduce Metropolitan's premiums tax liability.

The Mini-Met rider required employers to assume the obligation to pay all employee claims for benefits up to a "trigger-point" amount, defined as the actuarially predicted, monthly average level of the aggregate employee claims. Metropolitan remained obligated to pay all claims in excess of that amount. Because Metropolitan was primarily obligated to pay employee claims only after the trigger point was reached for a particular month, it charged the employers a premium reduced by 90 percent. Hence, rather than paying a single premium to Metropolitan as they had previously done, the employers who elected to adopt the Mini-Met rider paid pretrigger-point claims directly to the employees and paid the smaller premium to Metropolitan.

The employers obtained cash-flow benefits from the modified arrangement, since they had the use of their funds until claims were actually paid out. They obtained an additional, limited benefit if the total claims for any month did not reach the trigger-point amount. This situation was referred to as "favorable claims experience." Any amounts by which the aggregate level of claims was less than the trigger-point amount were carried forward to the next month, increasing the trigger-point amount for that month. However, there was no carryover from year to year. Further, the employers and Metropolitan anticipated a substantial reduction in premiums tax liability, expecting to calculate the tax solely on the basis of the reduced direct monthly payments to Metropolitan.

For the three tax years in question (1967-1969), Metropolitan urged that it was entitled to a 90 percent reduction in its tax liability as a consequence of the Mini-Met rider. The California Insurance Commissioner, unpersuaded by Metropolitan's position, levied a tax based upon the sum of the amounts employers paid to Metropolitan

as premiums plus the aggregate yearly claims paid to employees from employers' funds. On October 29, 1973, Metropolitan paid $969,363.80 in tax assessments and interest.[1] After the State Board of Equalization (Board) rejected its claim, Metropolitan sued for a refund and obtained a judgment for the full amount requested. The Board appeals from the ruling.

(1) The Legislature has defined insurance as "a contract whereby one undertakes to indemnify another against loss, damage, or liability arising from a contingent or unknown event." (Ins. Code, § 22.) Thus, insurance necessarily involves two elements: (1) a risk of loss to which one party is subject and a shifting of that risk to another party; and (2) distribution of risk among similarly situated persons. (See *California Physicians' Service* v. *Garrison* (1946) 28 Cal.2d 790, 803-804 [172 P.2d 4, 167 A.L.R. 306]; 12 Appleman, Insurance Law and Practice (1981) § 7001, p. 4).

That the employees are the insureds under employer-provided group health insurance plans cannot seriously be disputed. We plainly stated in *Elfstrom* v. *New York Life Ins. Co.* (1967) 67 Cal.2d 503, 514, footnote 9 [63 Cal.Rptr. 35, 432, P.2d 731], that "the employee, in the tri-partite group insurance situation is the real insured under the policy." More generally, Insurance Code section 23 provides that "the person indemnified is the insured." Employee health plans cover the risk of injury or disability of the employees; the employees receive indemnification where such loses occur. That the employer may be the nominal policyholder is not significant; the employees remain those against whose potential loss the insurer provides indemnification.

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[1] The parties hve stipulated that Metropolitan is entitled to a judgment of refund in the amount of $12,690 plus $3,362.85 paid as interest, plus interest on both amounts as provided in Revenue and Taxation Code section 13107. The amount overpaid was the result of a typographical error in the tax assessment for 1968.

Although willing to assume arguendo that the employees are the true insureds under the type of arrangement here at issue, Metropolitan nevertheless maintains that the employees are insureds of Metropolitan only to the limited extent of its "excessive risk" coverage. Metropolitan would have us characterize the Mini-Met plan as purely an excessive risk policy; Metropolitan asserts that the employers are separate insurers as to all employee claims aggregating less than the trigger-point amount. Thus, reasons Metropolitan, the cost of the employer-provided portion of the medical benefit coverage is not taxable as gross premiums because the employer is not an "insurer doing business in this state" within the meaning of the taxing provisions here at issue.[2] The Board counters with the argument that Metropolitan was the sole insurer under the Mini-Met plan, bearing the entire insurance risk.

The Board relies heavily on *California Physicians' Service* v. *Garrison* (1946) *supra*, 28 Cal.2d 790, to support its position. The California Physicians' Service (CPS) was a nonprofit corporation formed to provide affordable health care coverage to low income persons. CPS collected monthly dues from the insureds, who were termed "beneficiary members" of the corporation; it distributed the dues to physicians—termed "professional members"—in payment for medical services rendered to the beneficiary members. The physicians had agreed to seek compensation solely from the fund created by dues collection. Thus, when the amount of dues collected in a particular month was

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[2] Metropolitan cites *Cal-Western Ins. Co.* v. *St. Bd. of Equal.* (1957) 151 Cal.App.2d 559 [319 P.2d 19]. In that case, an employer had established an employee retirement plan, without insurance coverage. The employees contributed toward the plan through payroll deductions. Relying on the absence of a profit motive, the court held that the employer was not engaged in an insurance business and therefore was not subject to the gross premiums tax on the amount of employee contributions. (Accord, *Mutual Life Ins. Co. of N.Y.* v. *New York St. Tax Comm'n* (1973) 345 N.Y.S.2d 475 [32 N.Y.2d 348, 298 N.E.2d 632].)

insufficient to fully compensate all the physicians for their services, CPS would disburse to each physician a pro rata payment calculated according to the value of services rendered.

The main issue in *Garrison* was whether CPS was conducting an insurance business and therefore subject to statutes regulating insurers. Those statutes required, among other matters, maintenance of adequate financial reserves to guarantee that insurers would be able to fulfill their coverage obligations. We declined to subject CPS to the regulations applicable to insurance businesses, reasoning as follows: "The business of the Service lacks one essential element necessary to bring it within the scope of the insurance laws, for clearly it assumes no risk. Under the provisions of the contracts or group agreements, it is a mere agent or distributor of funds. . . . The professional member is compensated for his services solely from the fund created by the monthly dues of the beneficiary members. . . . Stated in terms of insurance, all risk is assumed by the physicians, not by the corporation. . . ." (*Id.*, at pp. 804-805).

We explained and modified the *Garrison* holding in *People* ex rel. *Roddis* v. *Cal. Mut. Assn.* (1968) 68 Cal.2d 677 [68 Cal.Rptr. 585, 41 P.2d 97]. (See also *Maloney* v. *American I. M. & H. Assn.* (1953) 119 Cal.App.2d 319, 325 [259 P.2d 503].) California Mutual Association (CMA) was a nonprofit association organized to reimburse physicians and hospitals who rendered services to CMA's members. CMA financed its operation by collecting periodic dues from its members. Some of the physicians had agreed to look exclusively to CMA for payment of the scheduled fees. Other physicians provided services to CMA members without agreeing to seek reimbursement from any particular fund. As to this latter group of doctors, the patient-members were personally liable for payment of their medical expenses if CMA failed to meet its obligations. The issue in *Roddis*, as in *Harrison*, was whether CMA was an "in-

surer" and hence subject to statutory financial responsibility requirements or a mere "health care service plan" exempt from the statutory requirements. Noting that the purpose of the statutes was to protect insureds and the public, we reasoned that a health care provider should be required to maintain financial reserves only when there was some possibility that the provider, should it default, would leave the insureds subject to personal liability to physicians who had rendered services to them. We stated: "Where indemnity features are present, the member bears the risk of personal liability for medical services. This is the insurance risk which can be protected against by financial reserves to assure that the member will receive the benefits for which he has paid. . . . We, therefore, conclude that where indemnity is a significant financial proportion of the business, the organization must be classified as an 'insurer' for the purposes of the Knox-Mills Plan Act. . . . Although CMA's contracts with [the first group of] physicians provide for direct service without indemnity, the remainder of the plan is one of insurance." (*Id.*, at pp. 682-683.)

In their briefs, the parties have exhaustively discussed *Garrison* and *Roddis*. A careful review of those two cases, however, leads us to conclude that although they are generally helpful to an understanding of the nature of insurance and the need for financial stability of insurers, they bear only tangentially on the issues in the present case. The purpose of the taxing provisions which we interpret here is not to protect insureds, but rather to exact payments from insurers doing business in California; the gross premiums measure is apparently designed to approximate the volume of business done in this state, and thus the extent to which insurers have availed themselves of the privilege of doing business in California. (See generally *Ind. Indem. Exch.* v. *State Bd. Equalization* (1945) 26 Cal.2d 772, 775-776 [162 P.2d 222].)

The presence or absence of insurance risk on the part of the employers is not alone determinative of Metropolitan's tax liability. A more illuminating inquiry is whether the purpose of the taxing provisions can best be fulfilled by including amounts paid on pretrigger-point claims within the gross premiums measure of Metropolitan's tax. To myopically focus on the employers' status diverts attention from this central issue. In attempting to fulfill the purpose of the gross premiums tax, it is preferable to look beyond the formal labels the parties have affixed to their transactions and seek, rather, to discern the true economic substance of the Mini-Met arrangement. We thus consider the insurance arrangement as a whole.

Insofar as *Garrison* and *Roddis* aid in the resolution of the issue here presented, they support the Board's argument that the employers under the Mini-Met arrangement functioned not as independent insurers but at "mere agent[s] or distributor[s] of funds." (*Garrison, supra*, 28 Cal.2d at p. 804.) Under the Mini-Met arrangement, Metropolitan retained control over many aspects of the administration of the total plan. Metropolitan determined the amount of all benefits to be paid in satisfaction of employee claims, both above and below the trigger-point, with the obligation to defend and the right to settle suits contesting rejection of claims. As to 13 of the 15 employers covered by the Mini-Met package, Metropolitan actually paid claims from the special accounts of the employers pursuant to authorization by the employers. Rather than paying the cost of group insurance directly to Metropolitan, these employers deposited the money into accounts under Metropolitan's control. The payments to employees from such accounts constituted an element of overall cost of the insurance package in the same manner as if those amounts had been paid to Metropolitan as "premiums" then forwarded to the employees by Metropolitan in satisfaction of the employee claims. For the purpose of calculating the gross premiums tax, we can discover no

reasoned basis for distinguishing between the situation here presented and the former arrangement between Metropolitan and the employers. Metropolitan continued to derive substantially the same benefit of doing business in California and should logically have continued to incur the same tax liability.

True, the employers were primarily liable for payment of pretrigger-point claims. However, the obligations of Metropolitan were inextricably intertwined with those of the employers. If an employer failed to make funds available for payment of pretrigger-point claims in any month, Metropolitan remained obligated to cover the unpaid claims, subject to reimbursement from the delinquent employer.[3] The Mini-Met arrangement would then automatically terminate and the standard Metropolitan coverage would revert into effect at the end of the month in question. The employer would then be liable to Metropolitan for a termination premium, equal to the total premiums which would have been payable to Metropolitan from the employer in the current policy year had the standard group policies remained in effect, less the sum of the Mini-Met premiums paid to Metropolitan in that year plus the claims actually paid to employees from employer funds in that year.

Furthermore, the employers had a fixed limit on the amount of funds they were obligated to make available in each month, a limit corresponding to the expected level

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[3] We have not ignored Metropolitan's explanation that the provision in question was inserted "for administrative convenience to be certain that if there were a breakdown in communication or an inadvertent hiatus [in payments] on the part of the employer, the employees woyuld get their checks without interruption." Metropolitan also points out that no employer has yet failed to pay a pretrigger-point claim. Neither of these facts, assuming them to be true, diminishes the effect of the clear legal liability of Metropolitan to make pretrigger-point payments if an employer should defualt for any reason, as, e.g., in the event of insolvency.

of claims. Metropolitan thus bore the substantial insurance risk under the Mini-Met arrangement—the risk that the actual level of claims for a given month might exceed the predicted level. Given this highly entangled, symbiotic relationship between the employers and Metropolitan, it is hard to accept Metropolitan's contention that in providing funds for payment of pretrigger-point claims, the employers were discharging their independent liabilities as separate insurers.[4]

The Board persuasively argues that the employers role vis-a-vis the employees was that of an agent for the insurer. Metropolitan rebuts by citing the trial court's "finding of fact" that "[i]n making the medical benefit payments for which it was obligated, the employer was acting as principal, for its own account, and not as agent for Metropolitan Life Insurance Company." Metropolitan cites a number of general authorities for the proposition that whether an agency relationship exists is normally a question of fact. (See *Seneris* v. *Haas* (1955) 45 Cal.2d 811, 831 [291 P.2d 915, 53 A.L.R.2d 124]; *Brokaw* v. *Black-Foxe Military Institute* (1951) 37 Cal.2d 274, 278 [231 P.2d 816].) It also cites cases holding that an employer is an agent of its employees when negotiating the terms of a group policy with the insurer. (See *Madden* v. *Kaiser Foundation Hospitals* (1976) 17 Cal.3d 699, 705 [131 Cal.Rptr. 882, 552 P.2d 1178]; *Blos* v. *Bankers Life Co.* (1955) 133 Cal.App.2d 147, 150-151 [283 P.2d 744].) These cases are not apposite because a factual question becomes a question of law when the facts can be viewed in only one way. *Elfstrom* v. *New York Life Ins. Co.* (1967), *supra*, 67 Cal.2d 503, is controlling on the question of agency.

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[4] Metropolitan's contention that the employers are separate insurers bearing the bulk of the insurance risk under the Mini-Met plan is rendered less persuasive by its earlier admission in its claims for refund that "there was no risk in connection with the normal claims for activity for which the deductible amount [the trigger-point amount] was calculated."

In *Elfstrom*, we overturned the trial court's factual finding that the employer's bookkeeper was not an agent of the insurer; the bookkeeper had included an ineligible employee within group insurance coverage. Even though the insurance company itself did not know or have reason to know of the employee's ineligibility, the knowledge of its agents—the bookkeeper and the employer—was inputable to the insurer. We held *as a matter of law* that "the employer is the agent of the insurer in performing the duties of administering group insurance policies." (*Id.*, at. p. 512.) *Elfstrom* was recently reaffirmed in *Bass* v. *John Hancock Mut. Life Ins. Co.* (1974) 10 Cal.3d 792, 797-798 [12 Cal.Rptr. 195, 518 P.2d 1147]. (See also *Bareno* v. *Employers Life Ins. Co.* (1972) 7 Cal.3d 875, 883 [103 Cal.Rptr. 865, 500 P.2d 889]; *Amberg* v. *Bankers Life Co.* (1971) 3 Cal.3d 973, 979 [92 Cal.Rptr. 273, 479 P.2d 633].)

(2a) An examination of the facts of this case leads us to the conclusion that the employers in this case, as in *Elfstrom*, acted as mere agents of an insurer. The function of the employers under the Mini-Met arrangement was extremely limited; 13 out of 15 employers did no more than to establish and fund, on a continuing basis, bank accounts out of which Metropolitan, by special authorization, disbursed benefit payments for employee claims aggregating less than the trigger-point amount in a particular month. The remaining two employers paid out benefits without the assistance of Metropolitan. Surely these activities fall within the ambit of "administration" of a group insurance policy and constitute doing business in California. Thus, the employers are to be treated as agents of Metropolitan, as a matter of law.

Having determined that there was but one insurer under the Mini-Met package and that the employers functioned as agents of the insurer, we arrive at the issue whether the pretrigger-point claims payments, although financed by the employers, should be included within the total amount on which Metropolitan must pay a gross-premiums tax.

Several cases pertain to the more general question of what amounts are included within the meaning of the term "gross premiums." The initial authority is *Ind. Indem. Exch.* v. *State Bd. Equalization* (1945) *supra*, 26 Cal.2d 772, in which we held that a fee paid to attorneys at the expense of subscribers to an insurance exchange was included within the meaning of gross premiums because it was an element of the cost of the insurance.

Groves v. *City of Los Angeles* (1953) 40 Cal.2d 751 [256 P.2d 309], repeated the analysis of *Ind. Indem. Exch.* There, the agent of a bail bond insurer charged a percentage commission on the bonds he sold. A portion of the commission was forwarded to the principal, the agent retaining the remainder to cover expenses and as remuneration for his services. We held that the entire amount paid to the agent was includible within the gross premiums measure, not just the portion ultimately received by the bail bond company. Our reasoning went as follows: "[T]he basic theory is that the amount paid by the insured for the insurance is the premium. Here, as the bail agent is the insurer's agent, what he receives from the applicant for the insurance—that is, what the applicant pays for the bail bond is the premium. What the agent receives, in legal effect the insurer receives. The so-called 'fees' received by the bail agent do not result in a reduction of the cost to the insured." (*Id.*, at p. 761; accord, *Stuyvesant Insurance Co.* v. *State Tax Comm'n* (1972) 39 App.Div.2d 804 [332 N.Y.S.2d 314].

The holding and principles of *Groves* were applied in *Allstate Ins. Co.* v. *State Board of Equal.* (1959) 169 Cal.App.2d 165 [336 P.2d 961]. There, the insurer charged a fee if the insured elected to make his payments in installments. The fee covered the additional expenses of the insurer occasioned by the need to collect multiple payments. The court required inclusion of the "installment payment fee" within the gross premiums measure, reasoning that a " '[p]remium' in the law of insurance means

the amount paid to the company for insurance. [Citation.] It has been defined as 'the sum which insured is required to pay.' " (*Id.*, at p. 168.)

(3) From the above cases we derive the general rule that the insurer is to be assessed a tax based on the total cost of the insurance coverage provided to the insured. Before applying this principle to the facts of the present case, we review some basic concepts relating to the calculation of insurance premiums. **(4)** "The gross premium, or the amount charged in a contract of insurance, ordinarily includes two elements, that is, the net premium and the loading. The loading, or the amount arbitrarily added to the net premium, is intended to cover the expenses of the company." (*Allstate Ins. Co.* v. *State Board of Equal.* (1959) *supra*, 169 Cal.App.2d at p. 168). The net premium under standard group policies is the expected level of claims payments. The loading ordinarily is composed of miscellaneous charges, including administrative costs of the insurer, a charge for assuming the risk that claims outlays will exceed the expected level, and an element of profit or dividends. **(2b)** Under the Mini-Met arrangement, the trigger-point amount is analogous to the net premium under a standard arrangement. As Metropolitan's expert testified, the second element of the cost of the Mini-Met plan, totalling 10 percent of its cost, is computed essentially by adding the costs of administration to the premium to compensate Metropolitan for assuming the risk that claims experience may fluctuate above the expected level or trigger-point. Thus, the amount the employers paid directly to Metropolitan under the Mini-Met plan—the only amount on which Metropolitan intended to pay a premiums tax—is analogous to the loading under a standard arrangement. To compute the total cost of the Mini-Met insurance package, we must add together the two elements of the premium, the net premium and the loading. Thus, the gross premium is composed of the sum of the actual pretrigger-

point claims payments and the amount paid directly to Metropolitan as premiums.

Metropolitan argues that part of the cost of the Mini-Met plan is paid by the employers, not by the employees. This argument is said to support Metropolitan's ultimate contention that only those amounts paid to Metropolitan by the employers should be taxed as gross premiums. However, we view the situation differently. As will appear, we conclude that the employees, as a practical matter, bear the full expense of insurance coverage. In financing payment of pretrigger-point claims, the employers act as mere agents of Metropolitan, accumulating funds to be disbursed in a manner inuring to the economic benefit of Metropolitan.

Only in a formalistic sense can it be said that the employers bear the cost of the benefit plans which they provide to their employees. Group insurance coverage is an element of the employees' compensation and fringe benefit package negotiated through the collective bargaining process. The labor of the employees is the true source of the benefits, which are a form of additional compensation to them.[5] We fully concur in the following passage from *Insurance Co. of North America* v. *Bechtel* (1973) 36 Cal.App.3d 310 [111 Cal.Rptr. 507]: "Since the employer's contribution to the premium on group insurance is a fringe benefit, whether it be the full amount of the premium or

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[5] *Teamsters* v. *Daniel* (1979) 439 U.S. 551 [58 L.Ed.2d 808, 99 S.Ct. 790], cited by Metropolitan, does not compel a contrary result. There the court was considering whether employer contributions to a pension plan on an employee's behalf should be treated as an investment by the employee in a security. The court stated "Only in the most abstract sense may it be said that an employee 'exchanges' some portion of his labor in return for these possible benefits." (*Id.*, at p. 560 [58 L.Ed.2d at p. 817].) Viewed in context, the above-quoted statement does not contradict or even relate to our holding that employees are to be treated as the persons who finance employer-provided benefit plans for purposes of our state premiums tax.

only part of it, the extent of premium paid by the employer is not controlling. There is no practical difference between a pay raise to an employee out of which he pays part of the premium on his group insurance and direct payment of the premium by the employer." (*Id.*, at p. 317.) Although the court was addressing a different issue, the logic of its reasoning applies equally to the facts of the present case. **(5)** The tax liability of an insurer should not depend on the bare formality of whether the employer pays the cost of benefits out his own pocket or negotiates a pay raise with his employees, then deducts the cost of the plan from their salaries and forwards those amounts to the insurer. In both situations, the insurer obtains the same benefit of doing insurance business in this state. Accordingly, we hold that the entire cost of an employee benefit plan, whether paid from the employer's funds or financed by deductions from the salaries of employees, is taxable as gross premiums inuring to the benefit of the insurer.

Applying this rule to the facts of the instant case, we hold that Metropolitan is taxable on the sum of the premium payments it received from the employers and the pretrigger-point claims paid from employer funds in the tax years in question.

The judgment is reversed and the case remanded to the trial court with directions to enter judgment for Metropolitan only in the amount of the erroneous assessment described in footnote 1, *ante*.

Bird, C. J., Broussard, J., and Miller, J.,* concurred.

KAUS, J., Dissenting.—Article XIII, section 28 of the California Constitution imposes a tax on (1) gross *premium*, (2) *received* by (3) an *insurer*. The majority imposes this tax on (1) *losses* (2) *paid* to (3) *doctors and hospitals* and the like. What went wrong?

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* Assigned by the Chairperson of the Judicial Council.

I might join the majority if there were any evidence that the Mini-Met plan is just a bookkeeping trick by which Metropolitan intercepts 90 percent of the premiums at the source and, instead of running the money through its own books, causes it to be paid out directly to cover losses which Metropolitan would inevitably have incurred under the pre-Mini-Met arrangement. This kind of tax evasion could have been attempted by setting the trigger-point at an unrealistically low figure so that—barring a series of medical miracles—the actuarial possibility that the employers would actually save money by not having to disburse funds up to the trigger-point was nil. The fact—not mentioned in the majority opinion—is exactly the opposite: the record shows that in many months actual payments were well below the trigger-point *and that in 32 out of 42 policy years examined the total payments did not reach the trigger-point.*[1] Thus it cannot be contended that all the Mini-Met rider achieved was a fictitious reclassification of the first 90 percent of premium income as a deductible loss. Rather, the effect of the rider was just what is purported to be: it converted the pre-1967 full coverage policy into a genuine policy of excess insurance—quite similar to the deductible collision coverage must of us carry on our automobiles. If a motorist carries $100 deductible collision coverage and pays out $85 for a minor repair, no one can rationally claim that he is paying a premium, rather than a loss.[2]

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[1] The majority is therefore quite unjustified in saying that "[f]or the purpose of calculating the gross premiums tax, we can discover no reasoned basis for distinguishing between the situation here presented and the former arrangement between Metropolitan and the employers." (*Ante*, p. 657.) Is there no reasoned basis for distinguishing between payment for the actual cost of a small loss and payment of a premium for an actuarially anticipated greater loss?

[2] " 'Premium' in the law of insurance means the amount paid to the company for insurance." (*Allstate Ins. Co.* v. *State Board of Equal.* (1959) 169 Cal.App.2d 165, 168 [336 P.2d 961].) As a former Attorney

It is a safe guess that if Metropolitan and the employers had started to do business under the Mini-Met rider, the board would never have attempted the impossible: to convert excess insurance into full coverage. It is only because Metropolitan and the employers, for perfectly legitimate business reasons, changed plans in a way which resulted in considerable premium savings, that the board developed fancy theories to recoup its losses in tax revenue.[3] Yet all the evidence is to the effect, and the trial court expressly found, that "Mini-Met was not developed as a tax avoidance device. It was an excess insurance arrangement developed to effect, and did effect, substantial and bona fide changes in the financial, economic, contractual and legal relationships among Metropolitan, the employers and the employees from those existing under a full coverage insurance policy." The court further found that the impetus for the change from full coverage to Mini-Met came from the employers who "developed an increased awareness of the importance of 'cash-flow' management and investment of corporate funds.' " Some employers even considered 'shifting to non-insurance. It was only when faced with this loss of business that Metropolitan reluctantly started to offer the so-called "Met-Cat" plan, Mini-Met's predecessor. The trial court therefore concluded, after reiterating that Mini-Met was "not a tax avoidance scheme lacking in substance," that "it was 'compelled by business realities' and 'imbued with tax-independent considerations.' " While the business considerations which caused a

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General said of an insured's payment of the deductible portion of a loss: "Obviously this is not the price of any insurance and is in no sense a 'premium.' " (48 Ops.Cal.Atty.Gen. 49, 53 (1966).)

[3] The New York authorities were more generous. Prat of the record before us is a letter opinion from the New York Attorney General, dated December 27, 1966. In reply to a request of an opinion concerning the effect of Tax Law section 187 on what eventually became the Mini-Met rider, it said: "In my opinion, the amount of benefits paid out by employers to employees are in no sense a 'premium' received by the insurer and are therefore not taxable to the insurer under § 187."

genuine economic demand for a type of excess insurance such as Mini-Met are fairly set forth in the majority opinion, their significance becomes quickly lost in what I respectfully submit to be an irrelevant detour into the law of agency.

The basic fallacy of the majority opinion is revealed at its outset. It says that "[b]ecause we conclude that under the [Mini-Met] arrangement the employer *is a mere agent of Metropolitan for collection of premiums,* not an independent insurer,[4] we attribute the entire cost of the group plan to Metropolitan's gross premiums . . . ." (Italics added; *ante,* p. 652.) In support of its agency theory, the majority relies heavily on *Elfstrom* v. *New York Life Ins. Co.* (1967) 67 Cal.2d 503 [63 Cal.Rptr. 35, 432 P.2d 731], a case which in my view is not even remotely in point. That case held only that when an employer erroneously extends coverage to an employee who is not eligible for insurance, the insurer is bound by the employer's mistake because "the employer is the agent of the insurer in performing the duties of administering group insurance policies" vis-à-vis the insured employees. (*Id.,* at p. 512; accord, *Bass* v. *John Hancock Mut. Life Ins. Co.* (1974) 10 Cal.3d 792, 797-798 [112 Cal.Rptr. 195, 518 P.2d 1147]; *Bareno* v. *Employers Life Ins. Co.* (1972) 7 Cal.3d 875, 883 [103 Cal.Rptr. 865, 500 P.2d 889]; *Amberg* v. *Bankers Life Co.* (1971) 3 Cal.3d 973, 979 [92 Cal.Rptr. 273, 479 P.2d 633].) *Elfstrom* did not purport to hold that an employer is the agent of an insurer—as a matter of law—*for all purposes,* and it certainly did not decide that payments made by an employer to its employees' health providers from its own funds in

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[4] The majority seems to suggest that unless the employers are "insurers" for pretrigger-point losses, Metropolitan necessarily assumes that role. I disagree. The employers are simply fulfilling their contractual obligations toward their employees. If, in doing so, they run afoul of an unspecified part of the Insurance Code or some other law, that is another lawsuit. It certainly does not turn funds disbursed by them into premiums received by Metropolitan.

payment of its own contractual obligations should invariably be treated as gross premiums of an insurer which receives a different premium for covering a different risk. To say, as the majority does, that the employers in this case somehow "administered" Metropolitan's policy—a la *Elfstrom*—by paying pretrigger-point losses assumes the point to be proven: that these payments were not what they appeared to be, namely the employers' own losses, but payments to satisfy an obligation which Metropolitan had assumed by receiving a premium therefor, namely the payment made by the employers. The self-levitating nature of this argument is evident.

In contrast to the majority's conclusion, the trial court found that "in making the medical benefit payments for which it was obligated, the employer was acting as principal, for its own account, and not as agent of Metropolitan . . . ." The record not only justifies but compels that finding. As noted in the majority opinion two employers paid benefits below the trigger-point without any assistance by Metropolitan. Actually, out of a total of about $33 million of payments in issue, these two employers accounted for over $24 million—about 73 percent! How payments made by those two employers to satisfy their own obligations toward their own employees can be tortured into acts which "fall within the ambit of 'administration' of a group insurance policy" (*ante,* p. 659) is simply beyond me.

Legally the situation is no different as far as the other 13 companies are concerned. It will be recalled that they placed funds into accounts on which Metropolitan was permitted to draw in payment of claims below the trigger-point—payments for which the employers were responsible. Testimony at the trial described the arrangement as follows: "Generally a special bank account is set up where the employer wants the Metropolitan *to provide the claim service* on his liability, claim service being actually paying the claims . . . and he sets up a special bank account so that we can draw a draft on his account for the payment

of his benefit, for the payment of his liability." (Italics added.)[5] Naturally, where the insurance company has excess exposure for which it receives a premium, the cost of providing this claim service for losses below the excess is calculated into the premium, but the tax *on that premium* which Metropolitan concededly "received," is not at issue here. What the majority fails to explain is how Metropolitan's furnishing this type of claim service for funds which it has not, and never will, receive, justifies treating all of these funds of the employer as gross premiums received by Metropolitan. In any event, as to these 13 employers, it is obviously Metropolitan who is administering the employers' funds, and not—as the majority apparently claims—vice versa. I simply cannot understand how putting money into a bank account and watching it dwindle amounts to administering Metropolitan's policy.[6]

Having satisfied itself that the employers were agents of Metropolitan, the majority faces its biggest challenge—"the issue whether the pretrigger-point claims payments, although financed by the employers, should be included within the total amount on which Metropolitan must pay a gross-premiums tax." (*Ante,* p. 659.) It then analyzes several cases such as *Groves* v. *City of Los Angeles* (1953) 40 Cal.2d 751 [256 P.2d 309] to establish that the gross premium may include certain charges such as attorneys fees (*Ind. Indem. Exchange* v. *State Bd. of Equalization* (1945) 26 Cal.2d 772 [161 Cal.Rptr. 222]), commissions (*Groves, supra*), or an "installment payment fee." (*Allstate Ins. Co.* v. *State Board of Equal.* (1959) 169 Cal.App.2d

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[5] Testimony also revealed that employers who have no insurance at all can "rent" the claim service of an insurance company on an "ASO"—administrative services only—basis.

[6] The curious thing about the majority opinion is that it reaches its conclusion that "the employers are to be treated as agents of Metropolitan as a matter of law" just a few lines after correctly pointing out that the "function of the employers under the Mini-Met arrangement was extremely limited; . . ." (*Ante,* p. 659.)

165, 168 [336 P.2d 961].) Then, taking off from a statement in *Allstate* that premium rates are based on the expected losses ("pure premium") and expenses ("loading"), the majority jumps to the untenable conclusion that "[u]nder the Mini-Met arrangement, the trigger-point amount is analogous to the net premium under a standard arrangement." (*Ante,* p. 660.) In other words, the premium which the employers do *not* pay is really part of the net premium received by Metropolitan! Obviously this argument too simply assumes the result it strives to reach: that the employers are insured up to the trigger-point and that when they pay a pretrigger-point loss, they are really paying a premium.[7]

Even so, the majority is not out of the woods. After all the taxable event is the *receipt* of premiums by Metropolitan—as is recognized at the outset of the opinion by the statement that the court reverses because "the employer is a mere agent of Metropolitan for the *collection* of premiums . . . ." (*Ante,* p. 652; italics added.) So far all we have seen the employer do is pay out losses—either on its own account, as the trial court found, or on behalf of Metropolitan, as the majority asserts. Not one penny of premiums has so far been collected for pretrigger-point "coverage."

The majority gets over this final hurdle by holding that the premium is collected by the employers when they receive the labor of the insured employees. "The labor of the employees is the true source of the benefits . . . ." (*Ante,* p. 661.) The only trouble with that theory is that the tax claimed by the board has nothing to do with the value of the labor rendered by the insureds. To the contrary, the board asserts that the *losses paid* are the meas-

---

[7] What about the premium savings in the 32 policy years when losses did not reach the trigger-points? Presumably the employers owe these funds to Metropolitan and, to be consistent, the board should claim that they are gross receipts. One can only speculate why it lacked the requisite chutzpah.

ure of the tax liability. Obviously when one deals with a medical benefit plan, these should be in inverse proportion to the value of the labor rendered.

It is therefore submitted that the board's effort to transform an excess policy into one that provides full coverage will not stand up. It remains to dispose of a couple of points made by the majority to assert by implication that the "symbiotic" relationship between Metropolitan and the employers can somehow make the legal realities disappear.

First, there is the point that if the 13 employers who did avail themselves of Metropolitan's claims service failed to provide sufficient funds for pretrigger-point losses, Metropolitan was nevertheless obligated to advance money to pay for the losses, subject to reimbursement by the employers—a clean debtor-creditor relationship which by no means turns Metropolitan from a creditor into an insurer. The fact that an employer may become insolvent and leave Metropolitan holding the bag is a normal risk of doing business which was, presumably, taken into account in calculating the "loading" portion of the premium for the excess coverage, on which Metropolitan concedes that it was properly taxed. In any event, the argument has no application to the two employers who handled their own claims and whose payments comprised about 73 percent of the $33 million total.

Second, the majority points to the fact that Metropolitan "determined the amount of all benefits to be paid in satisfaction of employee claims, both above and below the trigger-point, with the obligation to defend and the right to settle suits contesting rejection of claims." (*Ante*, p. 657.) There is, of course, nothing unusual in that kind of arrangement. Metropolitan's obligations under it are simply part of the "administrative services" which it rendered to the employers; its rights derive from the fact that it is, after all, an excess insurer and has a vital interest in making certain that the excess risk it insured is not pre-

maturely triggered by payment of unjustified, uninsured losses. Metropolitan's primary power to determine the extent of pretrigger-point losses is obviously subject to a covenant of good faith and fair dealing. (See *Kaiser Foundation Hospitals* v. *North Star Reinsurance Corp.* (1979) 90 Cal.Ap.3d 786, 792-793 [153 Cal.Rptr. 678]; cf. *Commercial Union Assurance Companies* v. *Safeway Stores, Inc.* (1980) 26 Cal.3d 912, 921 [164 Cal.Rptr. 709, 610 P.2d 1038].)

I would affirm.

Reynoso, J., and Barry-Deal, J.,* concurred.

Respondent's petition for a rehearing was denied November 29, 1982. Richardson, J., and Newman, J., did not participate therein.

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* Assigned by the Chairperson of the Judicial Council.

APPENDIX G

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

JASPER BALLANCE, *et al.*
Plaintiff-Appellants,

vs.

CALIFORNIA STATE BOARD OF EQUALIZATION, *et al.*,
Defendant-Appellees.

No. 86-6192

ORDER DISMISSING THE APPEAL AS MOOT

Filed Oct. 29, 1987

Before: ALARCON and NELSON, Circuit Judges, and *MUECKE, District Court Judge.

The appeal in the above captioned action is hereby DISMISSED as moot. This case is removed from the Court Calendar for Monday November 2, 1987 in Pasadena, California.

This Court's opinion in *General Motors Corp. v. California State Board of Equalization*, 815 F.2d 305 (9th Cir. 1987), which was decided after the filing of the notice of appeal in this case, renders moot the issues set forth in the claim filed against the appellees. *See In re Charlton*, 708 F.2d 1449, 1454 (9th Cir. 1983).

We dismiss this appeal as moot because our decision in *General Motors* prevents this court from granting the relief

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*The Honorable C.A. Muecke, United States District Judge for the District of Arizona, sitting by designation.

requested by appellants in their original complaint. *See Matter of Combined Metals Reduction Co.*, 557 F.2d 179, 187 (9th Cir. 1977). Specifically, the following claims are moot for purposes of this appeal:

> Appellants' claim that appellees are collaterally estopped from collecting the tax is moot because the trial court's judgment, relied on by appellants, has been reversed by this Court.
>
> Appellants' claims relating to class certification issues are moot because, under *General Motors*, appellees' efforts to collect the tax do not inflict harm on at least some of the members of the proposed class.
>
> Appellants' request for a preliminary injunction to restrain appellees from collecting the tax until *General Motors* was decided on appeal is moot because the case has been decided.
>
> Appellants' request for a permanent injuction restraining the assessment and collection of the tax is moot because this court determined in *General Motors* that the tax is not preempted by ERISA.

In accordance with the Supreme Court's guidance in *United States v. Munsingwear*, 340 U.S. 36, 39 (1950), we dismiss this appeal and vacate the district court's judgment. This action is remanded to the district court, leaving the parties "in the same position in which they would have been" had the district court never reached a decision. *In re Charlton*, 708 F.2d at 1452. We express no opinion as to the merits of appellants' new theory advanced in the Brief In Response to the Order to Show Cause, filed October 26, 1987, that *General Motors* only controls taxation as to single employer employee benefit plans. The issue is not properly before this Court.

VACATED AND REMANDED.

(2)

No. 87-994

Supreme Court, U.S.
FILED
FEB 11 1988
JOSEPH F. SPANIOL, JR.
CLERK

In the Supreme Court

OF THE

United States

OCTOBER TERM, 1987

GENERAL MOTORS CORPORATION and
AMERICAN NATIONAL RED CROSS,
Petitioners,

VS.

WILLIAM M. BENNETT, CONWAY H. COLLIS,
ERNEST J. DRONENBURG, JR., RICHARD NEVINS,
GRAY DAVIS, and BRUCE BUNNER,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

JOHN K. VAN DE KAMP
Attorney General of the State of California
TIMOTHY G. LADDISH
Supervising Deputy Attorney General
(Counsel of Record)
350 McAllister Street, Rm. 6000
San Francisco, CA 94102
Telephone: (415) 557-0792
Attorneys for Respondents

BOWNE OF SAN FRANCISCO, INC. • 190 NINTH ST. • S.F., CA 94103 • (415) 864-2300

75 pp

QUESTIONS PRESENTED

1. The California Insurance Tax is a tax upon the privilege of doing insurance business in California. The tax is measured by the gross premiums cost to the insured parties of their insurance coverage. To compute the tax, that measure must be valued in dollars. In this case, California is taxing the insurance business of Metropolitan Life Insurance Company as to certain group insurance policies under which the insureds, petitioners' employees, are paying their premiums in the form of labor. In order to assign a dollar value to those labor premiums, California has made a purely computational reference to the equivalent dollar amounts of certain policy claims; these claims (1) were fully funded by the labor premiums, (2) were paid to the insureds, pursuant to the terms of a Metropolitan policy rider, from dollars retained in the employers' accounts, and (3) were claims which insurer Metropolitan was obligated to pay if they were not paid from the employers' accounts for any reason. Did the Court of Appeals properly hold that California's method of imposing insurance tax liability upon Metropolitan is protected by the ERISA saving clause and not affected by the ERISA deemer clause?

2. If this Court were to grant the petitioners' petition, respondent would urge several additional grounds to support the judgment reached by the Court of Appeals; these grounds would raise the following issues:

   a. Does the California Insurance Tax, which does not directly or indirectly regulate the contents or procedures of any ERISA plan, "relate to" an ERISA "plan" in such a way as to merit application of ERISA's § 514(a) preemption clause?

   b. When non-taxpayers such as petitioners enter into a contract to reimburse the taxpayer insurance company for costs incurred from such taxation, does such a voluntary agreement give petitioners standing to sue to enjoin collection of the tax, unaffected by the Tax Injunction Act?

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No. 87-994

In the Supreme Court

OF THE

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OCTOBER TERM, 1987

GENERAL MOTORS CORPORATION and
AMERICAN NATIONAL RED CROSS,
Petitioners,

VS.

WILLIAM M. BENNETT, CONWAY H. COLLIS,
ERNEST J. DRONENBURG, JR., RICHARD NEVINS,
GRAY DAVIS, and BRUCE BUNNER,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

STATUTORY AND CONSTITUTIONAL PROVISIONS

Petitioners have set forth selected portions of section 514 of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144, omitting applicable portions such as subsection (d) and including subsection (b)(5)(B)(i), which is only applicable to the Hawaii Prepaid Health Care Act under the terms (omitted by petitioners) of subsection (B)(5)(A). Section 514 of ERISA is set forth in its entirety in Appendix A hereto, along with the McCarran-Ferguson Act (15 U.S.C. §§ 1011-1015), the Tax Injunction Act (28 U.S.C. § 1341), and the primary California constitutional and statutory provisions regarding the Califor-

nia Insurance Tax (Cal. Const., art. XIII, § 28; Cal. Rev. & Tax. Code §§ 12201, 12221).

STATEMENT OF THE CASE

Respondents dispute many of the argumentative statements in petitioners' Statement of the Case. Respondents believe that denial of the petition will follow as a natural result of clarification of the record. Respondents' statement of the case will be a succinct presentation of the case before this Court; the more lengthy discussion of how petitioners have misstated the case is contained in the argument, below at pages 5-13.

Petitioners' employees were the insured parties under insurance policies issued by the Metropolitan Life Insurance Company ("Metropolitan"). Appellants' Excerpt of Record (hereinafter "A. Exc.") 1203-1240 (Appendix B hereto). Added to the basic insurance policies were so-called "Mini-Met" riders, which reduced none of the insurance benefits provided to the employees under the policies. A. Exc. 590-640. Said riders did change several procedural aspects with regard to the amounts needed to pay claims up to the "trigger point", which is the aggregate amount of claims that actuarially are predicted to arise under said policies for each set period. Instead of directly turning over these amounts to Metropolitan as the net premium portion of the insurance premiums, the employers retain those amounts in their own accounts but make the funds available for withdrawal for payment of claims up to that "trigger point". A. Exc. 569, lines 6-9, 572, 591-92 (Appendix C hereto at C2-C4). Once the trigger point has been reached, Metropolitan pays all remaining claims made for that period. A. Exc. 591 (App. C2-C3). Metropolitan also retains insurance liability under its policies to pay out of its own funds any valid pre-trigger point claims that are not paid from the employers' funds for any reason (such as an employer's insolvency). A. Exc. 591 (App. C3). With the exception of one policy, Metropolitan also retains control of approval as to *all* claims and writes the checks for pre-trigger point claims out of the employers' accounts. A. Exc. 571-72, 579-80.

One of Metropolitan's major purposes in drafting the "Mini-Met" rider was to try to avoid approximately 90 percent of state insurance taxes paid under the standard contract. A. Exc. 1182, lines 16-19, 1247. When California accepted the "Mini-Met" form for use in California, Metropolitan was informed that it would not gain such tax benefits under California law. A. Exc. 1246.

In a case involving pre-ERISA years and other employers but the same Metropolitan policy and rider forms, the California Supreme Court held as follows: (1) under the policy with the "Mini-Met" rider added, Metropolitan continued to be the only insurer; (2) the California Insurance Tax is measured by gross premiums, the total cost of the insurance to the insured parties, who (under Metropolitan's policy documents) were the employees; (3) insurance premiums consist of two elements, the net premium (to fully fund the expected level of aggregate claims) and the loading (to fund the administrative costs of the insurer and to pay for the insurer's assumption of the insurance risk that claims outlays will exceed the expected levels); (4) through the provision of labor the insured employees bore the full expense of all insurance coverage provided under the policy; (5) the employers received the value of that labor as agents of Metropolitan; (6) since the dollar amounts paid out as pre-trigger point claims from the employers' accounts were fully funded by the net premiums element of the employees' labor premiums, the same dollar amounts could be assigned to value net premiums, then added to the dollar amounts paid directly to Metropolitan (equivalent to the loading premiums element) in order to give a dollar figure to the gross premiums measure of the tax. *Metropolitan Life Insurance Co. v. State Board of Equalization*, 32 Cal.3d 649, 658, 659-662; 652 P.2d 426, 186 Cal. Rptr. 578 (1982) (Pet. 37a, 49a-55a).

Metropolitan is not a party to the current action; however, Metropolitan has several tax refund actions pending in the California state courts to test the California approach for ERISA years. A. Exc. 83-271, 340-512. Petitioners in the current case are employers whose employees are insured under Metropolitan policies with the "Mini-Met" rider, and petitioners claim that

said policies cover the benefits of ERISA plans. Petitioners, claiming that California's actions constitute an indirect tax on ERISA plans, seek a declaration that ERISA pre-empts California's method of calculating its insurance tax, as well as an injunction from continuing collections to the extent they are based on such calculations. A. Exc. 11-13.

The District Court gave petitioners such declaratory and injunctive relief. Pet. 33a-34a. In an opinion written by Circuit Judge Anthony M. Kennedy, the Court of Appeals reversed, holding that the California tax at issue is preserved by the ERISA saving clause and not affected by the ERISA deemer clause. The Court of Appeals decision recognizes that California is not taxing ERISA benefits; it is using the claims paid from the employers' funds only as a means of valuing the total cost of the insurance provided, the gross premiums. *General Motors v. California State Bd. of Equalization*, 815 F.2d 1305, 1310-1311 (9th Cir. 1987) (Pet. 12a-15a). Rehearing was denied, and request for rehearing en banc was rejected. Pet. 35a-36a.

There is no conflicting decision from any other Court of Appeals panel in any Circuit.

ARGUMENT

I

PETITIONERS ATTEMPT TO RAISE ISSUES WHICH DO NOT REFLECT THE SUBSTANCE OF THE RECORD OR THE ACTUAL APPLICATION OF THE CALIFORNIA TAX; WHEN THE CASE IS CLARIFIED, THE ERISA SAVING CLAUSE AND DEEMER CLAUSE ISSUES ARE EASILY RESOLVED IN FAVOR OF THE CALIFORNIA TAX

A. Introduction

The arguments made in GM's[1] petition are not consistent with the record in this case. Contrary to GM's glib presentation in its petition, the record of this case establishes the following:

1. Every benefit involved in this case was covered by an insurance policy issued by the Metropolitan Life Insurance Company (hereinafter "Metropolitan"), under which the employees were the insureds;

2. Metropolitan had insurance obligations to the insured employees as to each and every said benefit;

3. Neither the employers nor the ERISA plans bore any insurance risk and thus were not "self-insured";

4. The California Insurance Tax was imposed on Metropolitan's privilege of doing insurance business in California, and the tax was measured by the premiums cost to the insured employees, not the cost to the plan;

5. Both the California Supreme Court and the Ninth Circuit Court of Appeals have recognized that, under the types of insurance policies involved here, California's application of the tax to Metropolitan does not in any way impose a tax on benefits paid from employers' funds: the dollar amounts of those benefits are used for purely computational purposes because they are necessarily reflective, dollar for

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[1] For purposes of brevity, references to "GM" in this brief include reference to both petitioners, General Motors Corporation and American National Red Cross.

dollar, of net premium values which have been paid in the form of labor by the insured employees.

GM concedes (Pet. 17) that there is no challenge to the power of California to tax an insurance company even though the insurer then passes the costs of said insurance tax on to the employers or the ERISA plans. Under GM's approach California can tax Metropolitan for the insurance business it conducts, and California can measure its tax by the premiums costs to the insured employees of obtaining Metropolitan's insurance coverage; the record in this case shows that California has done just that. However, GM argues that ERISA preempts the California tax to the extent that in doing so California makes any arithmetical reference to pre-trigger point benefits received by the employees, even if said reference is the most accurate way to determine part of the value of the employees' premiums costs. It makes no sense to conclude that a valid tax with a valid measure is rendered invalid because its measure is calculated in the most accurate available manner. Federal law does not support that nonsensical conclusion. California has only taxed Metropolitan for insurance business it conducts in California, and California has properly and accurately measured that tax by the premiums costs to the insured employees; under these circumstances there is no ERISA preemption, and GM's petition for writ of certiorari should be denied.

B. The Record Demonstrates That Metropolitan Provided Insurance Coverage to the Employees for All the Benefits Involved in This Case

GM's petition repeatedly asserts that Judge Kennedy's Ninth Circuit opinion permits California unlimited taxing powers as long as an insurance company provides the slightest amount of insurance coverage with respect to employees involved in an ERISA plan. Pet. 8, 10 n. 5, 13, 14. Such assertions are not based on references to the actual insurance documents contained in the record; they are based on assumptions that are directly contrary to the record. Petitioners, maintaining that "the insurance contracts are not relevant to these proceedings" (A. Exc. 1370) did not present to the lower court the specific Metropolitan group policies for petitioners' employees. However, the record does contain the

Metropolitan basic group insurance policy form which was originally presented by stipulation in the California case of *Metropolitan Life Insurance Co. v. State Board of Equalization*, 32 Cal.3d 649 (1982) (Pet. 37a), and petitioners have accepted the facts as found in the California Supreme Court decision. (Transcript of hearing of August 24, 1984, page 5, lines 18-19.) This Metropolitan group policy form with excerpts from its standard policy riders (A. Exc. 1203-1240) is Appendix B ("App. B") to this brief; a representative sample of the so-called "minimum premium" or "Mini-Met" amendments or riders to existing group policies for petitioners' employees (A. Exc. 590-596), is Appendix C ("App. C") hereto. Considered together, these documents illustrate the scope of Metropolitan's business of insurance; the true illustration is strikingly dissimilar to the picture painted in GM's petition.

It is clear from the terms of the Metropolitan group policy form that (1) the employees are the insured parties under the policy and (2) under this policy Metropolitan is providing insurance as to all listed benefits (A. Exc. 1203-1209, 1215-1240; App. B1-B7, B15-B25). The "Mini-Met" rider, which amends the basic policy only in certain respects, does not change the status of the employees as the insureds; nor does it reduce in the slightest the level of benefits to which the insured employees are entitled under the Metropolitan insurance policy. Under the rider's terms, Metropolitan retains potential liability to the insured employees for the payment of *all* valid claims, whether or not aggregate claims have exceeded the trigger point; although the employer has agreed with Metropolitan to pay all claims up to the trigger point, the rider continues Metropolitan's obligation to pay such claims if the employer does not, even if the employer should become insolvent. See, *e.g.*, A. Exc. 591 (para. 4) (App. C2-C3); *Metropolitan Life Insurance Company v. State Board of Equalization*, 32 Cal.3d at 657 n. 3 (Pet. 49a).

As between the employer and Metropolitan, under the "Mini-Met" rider GM has agreed to fund all "expected (*i.e.* pretrigger point) benefits," with Metropolitan paying all claims once that aggregate predicted level has been reached. Pet. 7; A. Exc. 569, lines 7-9. Since it is the insured employees that are actually paying the premiums for their insurance coverage through their

labor (*Epmeier v. United States* 199 F.2d 508, 510 (7th Cir. 1952); *Metropolitan Life Insurance Company v. State Board of Equalization, supra*, at 661 (Pet. 54a-55a)), and since the net premiums element of such insurance premiums always includes payment sufficient to fund expected claims (see A. Exc. 570, lines 14-17, 578-79; and the opinion below, 815 F.2d at 1310 (Pet. 13a) and authority cited therein), GM has assumed absolutely no insurance risk under the Mini-Met rider. As before, it is Metropolitan which continues to bear the entire insurance risk (in GM's own affiant's terms, the "genuine insurance component," A. Exc. 571, line 8) that the aggregate level of claims will exceed predictions. In other words, Metropolitan continued as the only true insurer for all the benefits provided under this policy; GM was not "self-insured" in that it was neither the insured party in the first place under the policy nor did GM bear any insurance risk of having to pay out more than it had received in value from its employees to fund the entire insurance coverage. Thus GM itself, in a booklet describing ERISA rights, assured its employees that "[T]he GM Insurance Program is an insured welfare benefit plan . . . ," and that "*all* life and disability benefits, as well as Health Care benefits for certain employees, are provided through the Metropolitan Life Insurance Company." A. Exc. 1770 (emphasis added).[2]

In addition to (and apparently because of) the potential payment obligations which Metropolitan retained as to all claims under the insurance policy, Metropolitan continued to be intimately involved in the administration of all claims. Metropolitan had the final say as to allowance or disallowance of *all* claims litigation and settlements. See, *e.g.*, A. Exc. 592, para. 8 (App. C4-C5). Except for one area of one of the GM policies, Metropolitan apparently performs the administrative claims duties for

[2] Similarly, the booklet describing the "Group Insurance Plan" for the American Red Cross staff (A. Exc. 1853-1883) set forth the available benefits and simply stated: "The plan is underwritten by the Metropolitan Life Insurance Company." A. Exc. 1854. The insurance provided by Metropolitan in this case bears no resemblance to the arrangement as described in *General Electric Co. v. Gilbert*, 429 U.S. 125, 128 n. 3 (1976), upon which GM relies (Pet. 7).

all claims and writes the checks for pre-trigger point benefit claims out of the employers' accounts. A. Exc. 571-72, 579-80.

It is this factual context, not the fanciful version drawn by GM in its petition, to which California applies its insurance privilege tax. It is ironic that GM, whose petition repeatedly decries any possible elevation of form over substance (Pet. 1-2, 15), expects this Court to base its actions in this case on mere labels which GM has applied to surface appearances resulting from Metropolitan's artful drafting of its Mini-Met rider, without any consideration of the actual insurance relationships which form the substance of Metropolitan's continuing insurance coverage.[3] The terms of the Ninth Circuit's decision properly are limited to the facts in the record before it. GM has no basis for its assertions that the Ninth Circuit's *GM* holding supports unlimited state taxation without regard to the amount of insurance actually provided by the insurance company: the Ninth Circuit holds that the challenged procedures are used only as a means of capturing the total cost of the "insurance provided" (Pet. 13a); this holding is supported by reference to the California Supreme Court's *Metropolitan* decision, which properly held that Metropolitan was the "one insurer under the Mini-Met package" (32 Cal.3d at 659 (Pet 51a)) and which held that under California law the insurer's tax amount was to be based on the total cost of "the insurance coverage provided" to the insured employees (32 Cal.3d at 660 (Pet. 53a)).[4] This case must be decided on the basis of the record

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[3] One of Metropolitan's primary goals in drafting the Mini-Met rider was to reduce insurance tax liability (App. Exc. 1182, lines 16-19, 1247); at the time the Mini-Met rider form was accepted for use in California, Metropolitan was informed that it would not achieve those tax benefits under California law (App. Exc. 1246).

[4] Instead of supporting GM's position (see Pet. 10 n. 5), the Ninth Circuit's reference to *Moore v. Provident Life & Accident Insurance Co.*, 786 F.2d 922 (9th Cir. 1986) and *United Food and Commercial Workers v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986) only serves to indicate the Ninth Circuit's awareness of the scope of the insurance coverage provided by Metropolitan in this case. In his *GM* opinion Judge Kennedy distinguishes *Moore* and *Pacyga* on the basis that "insurance [was] not involved in any meaningful sense in either case" (Pet. 14a-

and opinion actually before this Court, not on GM's purported fears of how California or other states might attempt to apply the *GM* result to other, broader circumstances.

C. Petitioners' Arguments Are Based on a Faulty Premise, for California Is Neither Taxing ERISA Plan Benefits Nor Treating Them as Premiums

Throughout the petition GM bases its arguments on repeated statements that California has imposed a tax on ERISA plan benefits. See, *e.g.*, Pet. 2, 12, 14, 15. Indeed, in its first paragraph the petition asks this Court to determine whether ERISA permits "purposeful . . . state taxation of ERISA benefits . . ." Pet. 2. In this regard GM asserts that the California Supreme Court has deemed plan benefits to be insurance premiums (see Pet. 7, 16-17, 18), and that the Ninth Circuit did not disagree with the District Court's conclusion that California was indirectly taxing ERISA benefits (Pet. 10, 15 n. 9). All such statements in the petition are simply wrong; they are based on misinterpretations of the opinions of both the California Supreme Court and the Ninth Circuit Court of Appeals.

Metropolitan's drafting of its "Mini-Met" rider has resulted in California's reference to dollar amounts of benefits paid from employers' funds, but those amounts are used purely as a computational tool in valuing the *premiums that are provided by the employees*, not the employers. A review of California's Insurance Tax and its true application in this case discloses that California is not treating such benefits as premiums and is not taxing such benefits directly or indirectly.

The California Constitution imposes a privilege tax "on each insurer doing business" in California, measured by the amount of "gross premiums" which the insurer receives each year. Cal. Const., art. XIII, § 28; Cal. Rev. & Tax. Code, § 12201, 12221; *Carpenter v. Peoples Mutual Life Insurance Co.* 10 Cal.2d 299, 302, 74 P.2d 508, 510 (1937). Dealing with pre-ERISA years, in *Metropolitan Life Insurance Co. v. State Board of Equalization, supra*, 32 Cal.3d 649 (Pet. 37a), the California Supreme Court

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15a), thus recognizing that a much greater amount of insurance was provided by Metropolitan in *GM*.

ruled on the issue of how to calculate the "gross premiums" measure when faced with the surface complexities of Metropolitan's "Mini-Met" arrangement. Drawing upon long-established California insurance tax law, the California Supreme Court held that the entire cost to the insured employees of the insurance coverage provided under the Metropolitan insurance contract was includible in Metropolitan's gross premiums for the years 1967-1969, even though Metropolitan had tried to shield a significant portion of the premiums from the measure of tax.

The California Supreme Court held that the employers were not independent insurers but rather merely received the premiums from the employees as collection agents of Metropolitan. *Id.* at 652, 659 (Pet. 42a, 51a). *The Court further held that the insured employees, through their provision of labor, bore the full expense of the insurance coverage*: The Court recognized that for every dollar of pre-trigger point claims (i.e. benefits) paid under the terms of the Metropolitan policy from the employers' funds, the insured employees had paid in a dollar's worth of net premiums in labor; thus under "Mini-Met" the employers' funds could not be responsible for paying out (in pre-trigger point claims and in direct payments to Metropolitan) any more than the employers had received in labor premiums from their employees, leaving Metropolitan to bear the substantial insurance risk. *Id.* at 658-59, 660-62 (Pet. 49a-51a, 53a-55a). The California Supreme Court held that the entire cost of the insurance to the insured employees (including an amount equal to the payments made from the employers to Metropolitan and an amount equivalent to the payments made out of the employers' funds to satisfy employee claims up to the trigger point) was included in the gross premiums measure of Metropolitan's tax under California Constitution Article XIII, section 14 4/5 (now sec. 28) and California Revenue and Taxation Code sections 12201 and 12221. *Id.* at 659-62 (Pet. 51a-55a).

Given the above, it is wholly incorrect and improper for GM continually to assert that California is imposing a tax on plan benefits. Rather, California imposes its tax upon Metropolitan for its exercise of the privilege of doing insurance business in California; California measures this tax by the gross premiums received

by the insurer, the amount of which is set under California law by determining the cost to the insureds of obtaining the insurance.[5] In the current context California's determination of such total costs to the insureds has been made more complex by Metropolitan's generation of the "Mini-Met" smokescreen, which (as shown above) did not alter Metropolitan's basic insurance relationship with the insured employees. Because of the drafting complexities injected by Metropolitan, California uses, *only as part of its computation* of the insured employees' premiums costs, the dollar amounts of the claims benefits paid from employer funds. A full review of the California Supreme Court's decision makes it clear that those dollar amounts are used arithmetically because they are necessarily reflective, dollar for dollar, of premium values incurred as insurance costs by the insured employees.

Contrary to GM's assertions, in the present case Judge Kennedy's opinion for the Ninth Circuit clearly recognizes that the claims payments paid from GM's funds are not being treated as premiums and are not being taxed by California. The Ninth Circuit, recognizing that the California Insurance Tax "is calculated in terms of premiums," further notes that under the "Mini-Met" facts California uses the dollar amounts of pre-trigger point claims payments solely as a computational reference:

> "Concededly, the tax is calculated with reference to benefit payments. The payments, however, are used only as a means of capturing the total cost of the insurance provided, the amount which appellants' premiums tax seeks to reach. *Metropolitan Life Ins. Co. v. State Bd. of Equalization,* 32 Cal.3d 649, 660, 652 P.2d 426, 186 Cal.Rptr. 578 (1982). Total cost has two elements, the net premium and the loading. The net premium is the amount which, invested properly, will yield a fund sufficient to pay expected claims. The loading is the amount added to the net premium to

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[5] GM tries to confuse the matter by referring to costs to "the plan" or costs to the employers; there can be no valid question that California has measured its Insurance Tax by the insurance premiums costs to the insured *employees. Id.* at 659-62 (Pet. 52a-55a).

cover the insurer's administrative costs and compensate it for assuming the risk that claims will exceed expected levels. *Allstate Ins. Co. v. State Bd. of Equalization*, 169 Cal.App.2d 165, 168, 336 P.2d 961, 964 (1959). Under a traditional policy, both elements are included in the premium paid the insurer, making that premium an accurate measure of the total cost of the insurance provided.

> "Here, the premium paid the insurer includes only the loading element, so a method for determining the dollar amount of the net premium element is necessary. As the benefits paid by the plans equal the net premium under a traditional policy, appellants have referred to those payments in calculating the tax. This reference, which is used to measure the cost of insurance provided accurately, does not deprive the tax of the protection of the saving clause, for the incidence of the tax remains on the insurer, not the plans." 815 F.2d at 1310 (Pet. 13a-14a).

Even if the measure of California's tax were considered to be the pre-trigger point claims, that would not convert this tax on the privilege of doing California Insurance business into a tax on those claims benefits. *See Educational Films Corp. v. Ward*, 282 U.S. 375, 389-390 (1931); *Flint v. Stone Tracy Co.*, 220 U.S. 107 (1911). Petitioners attempt to avoid this established rule by citing *American Bank & Trust Co. v. Dallas County*, 463 U.S. 855, 862 (1983), and *Ramah Navajo School Board v. Bureau of Revenue*, 458 U.S. 832, 845 (1982). Petitioners fail to mention that both these cases come within specific exceptions to the *Flint v. Stone Tracy* rule: *American Bank & Trust Co.* involved a federal statute that had been amended specifically to prohibit inclusion of certain types of exempt income in *any* computation involving a state tax, and *Ramah*, involving pre-emption of state taxation with regard to Indian tribes, explicitly noted that that type of pre-emption question "is not controlled by standards of pre-emption developed in other areas." 458 U.S. at 838. Neither exception applies here.

D. California's Application of Its Insurance Tax Is Protected by the ERISA Saving Clause and Not Pre-empted by the Deemer Clause

Once one dispels the smokescreen generated by petitioners, so that the scope of insurance provided by Metropolitan and the actual application of the California Insurance Tax become clear, there can be no real question that the Ninth Circuit has correctly held that California's tax, as applied in this case, is preserved by the ERISA saving clause. In the conclusion to their petition, petitioners concede "the power of the states to tax insurance companies even though the costs of the tax are passed through by the insurer to an ERISA plan." Pet. 17. Thus petitioners only challenge "the power of the states to tax benefits paid out by ERISA plans under the theory that such benefits constitute insurance premiums." Pet. 17-18. Since, as shown above, California does not here treat such benefits as premiums and does not here tax such benefits, petitioners are challenging phantoms that have no existence in the record now before this Court.[6]

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[6] Five of the six respondents herein apparently were named because of their membership on the State Board of Equalization, which assesses the California Insurance Tax (Cal. Const. art. XIII, § 28(h)). After its staff makes the preliminary assessment, the Board itself makes the final administrative review of whether an assessment will stand. If the Board denies refund relief, its decision is subject to full review by the California courts. The 1983 bulletin attributed by petitioners to "respondents" (Pet. 8) was issued solely by respondent Bunner, who has never been a member of the Board of Equalization and who is no longer Insurance Commissioner. No respondent would subject "Mini-Met" claims payments to taxation, and all respondents agree that such claims amounts are used only for the computational reference discussed above to measure Metropolitan's insurance business. A. Exc. 947. In any event, the issues in this case are limited by the record of this case; speculation as to what California or other states might do in other circumstances (see Pet. 8) is not a case or controversy which is now properly before this Court. Such speculative issues must first be considered and decided on properly developed trial records in the appropriate courts.

Even though the ERISA issue as framed by the petitioners is inapplicable to the record of this case, the petition's discussion of ERISA principles calls for clarification.

The Ninth Circuit has correctly indicated that, under this Court's decision in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 739-740 (1985), the ERISA insurance saving clause, 29 U.S.C. § 1144(b)(2)(A), "must be construed broadly, with due regard for the states' traditional powers in the field of insurance." 815 F.2d at 1310 (Pet. 12a). The Ninth Circuit also correctly holds that state taxation of the business of insurance was preserved under the saving clause:

> "The saving clause must also be construed to cover taxation of insurance. The clause preserves the McCarran-Ferguson Act's reservation of the business of insurance to the states. *Metropolitan*, 105 S.Ct. at 2392 n. 21. *McCarran-Ferguson*, in turn, preserves the states' ability to 'tax and regulate' insurance. *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 218, 99 S.Ct. 1067, 1076, 59 L.Ed.2d 261 (1979). Thus taxation of insurance, no less than regulation, may fall within the saving clause." 815 F.2d at 1310 (Pet. 12a-13a).[7]

As established above, California has applied its Insurance Tax to Metropolitan's privilege of doing insurance business in California; such a tax comes under the full protection of the McCarran-Ferguson Act. See *Western and Southern L.I. Co. v. Bd. of*

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[7]Subsection (d) of the ERISA section that deals with preemption provides that "[n]othing in this subchapter shall be construed to alter, amend, . . . impair or supersede any law of the United States . . ," thus confirming the full preservation of the McCarran-Ferguson reservation of the insurance business of insurance companies to the states. 29 U.S.C. § 1144(d); see *Northern Group Services v. Auto Owners Ins. Co.*, 833 F.2d 85, 91-92 (6th Cir. 1987).

Also, state taxation has been treated as being included as one type of state "regulation" in other federal pre-emption contexts. See *Wardair Canada, Inc. v. Florida Dept. of Revenue*, ___ U.S. ___, 106 S.Ct. 2369, 2372 (1986); *Ramah Navajo School Board v. Bureau of Revenue*, 458 U.S. 832, 838 (1982).

Equalization, 451 U.S. 648, 652-55 (1981). Unlike the state regulation involved in *Pilot Life Ins. Co. v. Dedeaux*, ___ U.S. ___, 107 S.Ct. 1549 (1987), this California tax is applied only to the insurance business of an insurance company and does not conflict with any of the other substantive or procedural provisions of ERISA.

Three McCarran-Ferguson "business of insurance" factors have been applied to test saving clause protection for non-tax state regulation in this Court's 1985 *Metropolitan* decision (471 U.S. at 742-743) and this Court's 1987 *Pilot Life* decision (107 S.Ct. at 1553-1554). These same factors also can be applied in this tax case to determine that California's tax is indeed being applied to the "business of insurance": (1) California's tax is being applied to Metropolitan's privilege of engaging in arrangements which transfer the risk of loss from the insured employees to Metropolitan (but not to the employers—see above at 7-8); (2) the privilege being taxed is what enables Metropolitan to enter into the policy relationship between Metropolitan as the insurer and the employees as the insureds; and (3) the tax only applies to entities within the insurance industry.

As to the ERISA deemer clause, 29 U.S.C. § 1144(b)(2)(B), the Ninth Circuit has correctly relied upon this Court's 1985 *Metropolitan* decision to conclude that "[t]he tax in issue does not run afoul of the deemer clause." 815 F.2d at 1310-1311; Pet. 14a. This Court's 1975 *Metropolitan* opinion designates "a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not." 471 U.S. at 747. Here the substance of the record indicates that Metropolitan provided insurance coverage to the insured employees for every benefit at issue, and that both petitioners presented their plans to their employees as insured plans. See above at pp. 7-8.[8] The fact that California, in determining the value of labor premiums

[8] Under the California Supreme Court's application of the "Mini-Met" arrangement, the *employers* are agents of Metropolitan for premium collection and limited disbursement purposes; but the employers are not insurers, for they incur no insurance risk. See above at pp. 7-8. The ERISA *plans* themselves are not even deemed to be agents, and

provided by the insured employees, merely referred to the doliar amounts of claims paid from employers' funds, will not result in "the evisceration of section 514 [29 U.S.C. § 1144]." See Pet. 16-17. That passive use of claims figures is a far cry from the effect of State regulation on the plan in *Metropolitan Life Ins. Co. v. Massachussetts*, wherein the state required insurance companies to carry a type of coverage for continuing benefits which were not otherwise included in the related ERISA plan.

Given the record of this case, including the breadth of the insurance actually provided by California and the very limited computational use California makes of the dollar amounts of the claims payments from the employers' funds, a "common-sense" application of the saving clause and the deemer clause results in no ERISA preemption of California's Insurance Tax as applied here. Under this Court's ERISA decisions, a state law which is protected by the McCarran-Ferguson Act (which protection is in part conditioned on no explicit conflict with the contents of another federal law such as ERISA) and which is imposed specifically and directly upon an insurance company will be protected by the saving clause and will not be pre-empted by the deemer clause. *See Metropolitan Life Ins. v. Massachusetts*, 471 U.S. 724, 739-747; *Pilot Life Ins. Co. v. Dedeaux*, 107 S.Ct. 1549, 1551-1555, 1558.

It would be the ultimate victory of form over substance and the total defeat of common sense to hold that California's computational reference to the dollar amounts of claims, which reference was the most accurate available means of valuing part of the labor premiums paid by the employees for the insurance coverage, must result in the pre-emption of most of California's insurance privilege tax on Metropolitan. Given the scope of Metropolitan's

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neither the plans not the employers are deemed to be engaged in the business of insurance.

It is not necessary here for California to rely upon the holding in *Northern Group Services v. Auto Owners Ins. Co.*, 833 F.2d 85, 95 (6th Cir. 1987), that the deemer clause does not preclude direct state regulation of even self-insuring ERISA plans when there is no demonstrated, specific ERISA uniformity interest which overrides the McCarran-Ferguson interest in state regulation of insurance.

insurance coverage, such a holding would only force California to use a less accurate means of trying to determine the same amount of the fully appropriate premiums measure of its tax. Nothing in ERISA requires such an inane result.

II

IF CERTIORARI WERE GRANTED, ADDITIONAL ISSUES SHOULD BE CONSIDERED REGARDING THE ERISA PREEMPTION CLAUSE, STANDING, AND THE TAX INJUNCTION ACT

A. Introduction

Respondents are not independently seeking review by this Court of the Court of Appeals' decision. However, if GM's petition were to be granted there should be review of several additional issues, which were decided by the Court of Appeal in petitioners' favor before judgment was rendered for respondents.

B. The Application of the California Insurance Tax Is Not Pre-empted by the ERISA Pre-emption Clause

Before its determinative holding on the ERISA saving clause, the Court of Appeals' opinion concluded that California's application of its insurance tax "'relate[s] to' employee benefit plans, thereby invoking ERISA's preemption clause, 29 U.S.C. § 1144(a)." 815 F.2d at 1309-1310, Pet. 10a-12a. That opinion was filed on April 29, 1987. On June 1, 1987, this Court further clarified the scope of the ERISA pre-emption clause in *Fort Halifax Packing Co., Inc. v. Coyne*, ____ U.S. ____, 107 S.Ct. 2211 (1987). Under *Fort Halifax* it is clear that the pre-emption clause is not applicable in this case.

Fort Halifax holds that the pre-emption clause does not apply to all "state laws relating to 'employee benefits,' but to state laws relating to 'employee benefit *plans*' ". 107 S.Ct. at 2215 (emphasis by the Court). Therefore, although in *Fort Halifax* the State of Maine was requiring a certain type of employee benefit, this Court held that requirement was not subject to the ERISA pre-emption clause "because the statute neither establishes, nor requires an employer to maintain, an employee welfare benefit

'plan' under that federal statute." *Id.* (Footnote omitted.) Even though the words "relate to" should be construed expansively (*id.*), "[n]othing in our case law . . . supports [the] position that the word 'plan' should in effect be read out of the statute." *Id.* at 2216.

As shown above (pp. 10-13), the state practice challenged here by GM is a mere computational reference to dollar amounts of insurance claims to be paid out under certain circumstances pursuant to the terms of an insurance policy issued by the Metropolitan Life Insurance Company.[9] In making this reference California is not dictating the terms of any ERISA plan, as New York was attempting in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); California is not even referring to the terms of any ERISA plan, for no ERISA plan containing the claims payment provisions at issue was ever submitted by petitioners to the California authorities or to the courts below in this case. Nor is California dictating the content of any insurance policy benefit terms, an action which would "relate to" an underlying ERISA plan under the pre-emption clause but be saved by the saving clause. *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 739, 744. Under the pre-emption clause test as most recently clarified in *Fort Halifax*, California's challenged action does not directly or indirectly establish, dictate the contents of, or require the maintenance of any particular *plan*. Even if California's computational reference to certain dollar amounts of insur-

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[9] Petitioners do not challenge California's ability to impose an insurance tax on Metropolitan "even though the costs of the tax are passed through by the insurer to an ERISA plan." Pet. 17. This is reasonable, since California can directly regulate the rates of the premiums charged by the insurance company without "relat[ing] to" any underlying ERISA plan. See *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 741, 728 & n. 2. In contrast, some of the amici supporting petitioners take the quite unreasonable approach that ERISA would pre-empt any state tax whose cost might be passed down indirectly to the employers in an ERISA plan. Such an approach would render all such business of insurance tax free, a result which would be directly contrary to the McCarran-Ferguson Act and which would find no support in the terms or legislative history of ERISA.

ance claims somehow "relates to" certain ERISA plan *benefits*, that reference does not "relate to" ERISA benefit *plans* under the ERISA pre-emption clause.[10]

"The presumption is against pre-emption . . . ." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 741. "ERISA pre-emption analysis 'must be guided by respect for the separate spheres of governmental authority preserved in our federalist system.' *Allessi v. Raybestos-Manhattan, Inc.*, 451 U.S., at 522, 101 S.Ct., at 1905 (1981). The argument that ERISA pre-empts state laws relating to certain employee benefits, rather than to employee benefit *plans*, is refuted by the express language of the statute, the purposes of the pre-emption provision, and the regulatory focus of ERISA as a whole." *Fort Halifax Packing Co., Inc. v. Coyne*, 107 S.Ct. at 2221.

C. Either the Nontaxpayer Petitioners Have No Standing, or This Action to Enjoin the Collection of a California Tax Is Barred by the Federal Tax Injunction Act

1. Introduction

In contractual agreements separate from the insurance policy documents, both petitioners agreed to reimburse Metropolitan for any taxes paid by Metropolitan which are of the type at issue in this case; in turn, Metropolitan agreed to seek relief from such taxes through all appropriate legal procedures. A. Exc. 1675-1676, 1850-1851. Petitioners have relied on these voluntary agreements as a direct link which provides them standing to sue state

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[10] The *Fort Halifax* recognition of the significance of the use of the term "plan" in the pre-emption clause fully comports with the limitation of ERISA pre-emption which is built into the pre-emption section's definition of the word "State." As noted in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981), "For purposes of the pre-emption provision, ERISA defines the term 'State' to include: 'a State, any political subdivision thereof, or any agency or instrumentality of either, which purports to regulate, *directly or indirectly*, the terms and conditions of employee benefit plans covered by this subchapter.' 29 U.S.C. § 1144(c)(2) (emphasis added)." In no way do the challenged California computational procedures "regulate, directly or indirectly, the *terms and conditions*" of any ERISA plans. (Emphasis added.)

officials for an injunction of the tax, but then petitioners have argued that these same agreements are too tenuous to bring petitioners under the federal Tax Injunction Act's prohibition of injunctions of the "assessment, levy or collection of any tax under State law where a plain, speedy and efficient remedy may be had in the courts of the State." 28 U.S.C. § 1341. Petitioners cannot have it both ways. For that matter, petitioners cannot have it either way.

2. Petitioners Have No Standing

The Court of Appeals' conclusion that petitioners had standing was based in large part on section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3). A statute cannot confer standing if there is no standing under the federal Constitution. *Valley Forge College v. Americans United*, 454 U.S. 464, 488 n. 24 (1982). "The requirement of standing . . . has a core component derived directly from the Constitution. A plaintiff must allege personal injury fairly traceable to the defendant's allegedly unlawful conduct and likely to be redressed by the requested relief." *Allen v. Wright*, 468 U.S. 737, 751 (1984).

In *Alien v. Wright* this Court, noting that "the standing inquiry must be answered by reference to the Art. III notion that federal courts may exercise power only 'in the last resort, and as a necessity,'" *id.* at 752, held that the plaintiffs therein could not assert their second claim of injury "because the injury alleged is not fairly traceable to the government conduct [plaintiffs] challenge as unlawful." *Id.* at 757 (footnote omitted). In the words of this Court, "The links in the chain of causation between the challenged Government conduct and the asserted injury are far too weak for the chain as a whole to sustain [plaintiffs'] standing." *Id.* at 759.

In the case at bar petitioners, by entering into the above contract with Metropolitan, purportedly have forged their own link to connect the challenged governmental action to the alleged injury they have directed upon themselves. That is like a man who purposely grips a lightning rod in a thunderstorm and then curses the heavens for his misfortune after the bolt strikes the rod. The disputed tax in this case was assessed solely against Metropolitan.

Petitioners have voluntarily contracted with Metropolitan to reimburse Metropolitan for the disputed tax. This voluntary assumption of liability to Metropolitan cannot create standing to sue the state, particularly on an issue that would be foreclosed to Metropolitan itself in the Federal courts.

3. The Tax Injunction Act Bars Relief

If petitioners' agreements to reimburse Metropolitan somehow have sufficient substance to create standing for petitioners to sue respondents, then the remedies provided by those same agreements should be considered in determining whether petitioners have a "plain, speedy and efficient remedy" in the California courts. If petitioners have such a plain, speedy and efficient remedy, the relief in this action is clearly barred by the language of the Tax Injunction Act, 28 U.S.C. § 1341.[11]

As noted above, petitioners' agreements with Metropolitan impose upon Metropolitan the duty to "seek relief from such premium taxes through all appropriate legal procedures. . . ." A. Exc. 1675, 1850. The record also shows that Metropolitan has such lawsuits pending in California courts. A. Exc. 83-512. Under the agreements petitioners have access to the California courts to protect petitioners from any failure by Metropolitan to fulfill its contractual obligations. In other words, GM could be made whole by suit to require Metropolitan to pursue its remedies and, if Metropolitan failed to perform, to obtain damages from Metropolitan under the GM/Metropolitan contract. This remedy, which fully mirrors the reimbursement obligations assumed by petitioners under their contracts, is a plain, speedy and efficient remedy sufficient to require application of the Tax Injunction Act.

As pointed out by the Court of Appeals, respondents recognize that, since petitioners themselves have not paid the taxes, peti-

[11] The Court of Appeals correctly has concluded that "ERISA actions are subject to the Tax Injunction Act." 815 F.2d at 1308, Pet. 9a, citing *Ashton v. Cory*, 780 F.2d 816, 821-22 (9th Cir. 1986). In addition to barring injunctive relief, the Act also prohibits declaratory relief invalidating state taxes. *California v. Grace Brethren Church*, 457 U.S. 393, 408 (1982).

tioners cannot sue the state or its officials in the California courts to challenge their collection. But petitioners' lack of remedy against the *state* does not mean they come within the Tax Injunction Act's exception. In order to accomodate judicial concerns and to "be faithful to the congressional intent 'to limit drastically' federal-court interference with state tax systems, [this Court] must construe narrowly the 'plain, speedy and efficient' exception to the Tax Injunction Act." *California v. Grace Brethren Church*, 457 U.S. 393, 413. There is no requirement in the Tax Injunction Act that the state remedy must be directly against the state if the plaintiff's burden is not imposed directly by the state. As to taxpayers themselves, this Court has held that the California tax refund procedures satisfy the requirements of the Tax Injunction Act. *Id.* at 413-417. Since Metropolitan clearly could not seek injunctive relief in federal court, and since the scope of the California remedy available to petitioners is fully proportionate to the reimbursement obligations they have assumed, petitioners should not be permitted to subvert the purpose of the Tax Injunction Act by seeking in their names the same federal relief which is so clearly barred to Metropolitan.

CONCLUSION

What is California doing that is the true target of petitioners' attack? In applying the California Insurance Tax to the California insurance business of Metropolitan, California merely takes the substance of Metropolitan's insurance policy as it presently stands and applies the pre-ERISA established rules of California insurance law, which rules are fully protected by the McCarran-Ferguson Act. Since Metropolitan, under its policy, provides the insured employees with insurance coverage for all of the benefits that policy provides, and since California, with its challenged reference to certain policy claims amounts, is making that reference solely for computational use in determining a dollar value for labor premiums paid by the insured employees, there is no prohibition in ERISA which eclipses the McCarran-Ferguson protection afforded to California.

California's application of its Insurance Tax does not restrict the range of insurance options open to ERISA fiduciaries. If, as in

this case, they choose insurance wherein an insurance company provides insured employees with insured coverage as to all claims; they should not be surprised when that insurance company is taxed accordingly. Petitioners' arguments as to the supposedly dire prospective effects of California's actions are directed at phantoms not present here: those arguments, as well as the arguments of each amicus brief filed in support of petitioners' position[12], are based on alleged circumstances of "self insurance" and "taxing of ERISA benefits" that simply are not present in this case. Those arguments should be made only when a plan truly is not fully insured and when a state truly is taxing ERISA benefits. That is not this case.

For the reasons given above, and because of the lack of any conflict among the Circuit Courts of Appeals, it is respectfully submitted that the petition for a writ of certiorari should be denied.

Dated: February 11, 1988

Respectfully submitted,

JOHN K. VAN DE KAMP
Attorney General of the State of California
TIMOTHY G. LADDISH
Supervising Deputy Attorney General
(Counsel of Record)
Attorneys for Respondents

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[12] Petitioners' application to this Court of October 30, 1987, sought an extension in order to "allow the Department of Labor more time to develop its view of the case" in order to reach a decision as to whether to file a brief in support of the petition. The time was extended, and the Department of Labor did not file such a brief.

APPENDIX A

29 U.S.C. § 1144 (ERISA § 514):

(a) Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b)(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw.Rev. Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section—

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts.

(6)(A) Notwithstanding any other provision of this section—

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides—

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii),

individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) shall not apply to qualified domestic relations orders (within the meaning of section 1056 (d)(3)(B)(i) of this title).

(8) Subsection (a) of this section shall not apply to any State law mandating that an employee benefit plan not include any provision which has the effect of limiting or excluding coverage or payment for any health care for an individual who would otherwise be covered or entitled to benefits or services under the terms of the employee benefit plan, because that individual is provided, or is eligible for, benefits or services pursuant to a plan under title XIX of the Social Security Act [42 U.S.C.A. § 1396 et seq.], to the extent such law is necessary for the State to be eligible to receive reimbursement under title XIX of that Act.

(c) For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

15 U.S.C. §§ 1011-1015 (McCarran-Ferguson Act)

§ 1011.

Congress declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

§ 1012.

(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relates to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, that after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade

Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

§ 1013.

(a) Until June 30, 1948, the Act of July 2, 1980, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, and the Act of June 19, 1936, known as the Robinson-Patman Anti-Discrimination Act, shall not apply to the business of insurance or to acts in the conduct thereof.

(b) Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

§ 1014.

Nothing contained in this chapter shall be construed to affect in any manner the application to the business of insurance of the Act of July 5, 1935, as amended, known as the National Labor Relations Act, or the Act of June 25, 1938, as amended, known as the Fair Labor Standards Act of 1938, or the Act of June 5, 1920, known as the Merchant Marine Act, 1920.

§ 1015.

As used in this chapter, the term "State" includes the several States, Alaska, Hawaii, Puerto Rico, Guam and the District of Columbia.

28 U.S.C. § 1341 (Tax Injunction Act):

§ 1341.

The district courts shall not enjoin, suspend or restrain the assessment, levy or collection of any tax under State law where a plain, speedy and efficient remedy may be had in the courts of such State.

California Constitution, Art. XIII, § 28 (in pertinent part):

SEC. 28. (a) "Insurer," as used in this section, includes insurance companies or associations and reciprocal or interinsurance exchanges together with their corporate or other attorneys in fact considered as a single unit, and the State Compensation Insurance Fund. As used in this paragraph, "companies" includes persons, partnerships, joint stock associations, companies and corporations.

(b) An annual tax is hereby imposed on each insurer doing business in this state on the base, at the rates, and subject to the deductions from the tax hereinafter specified.

(c) In the case of an insurer not transacting title insurance in this state, the "basis of the annual tax" is, in respect to each year, the amount of gross premiums, less return premiums, received in such year by such insurer upon its business done in this state, other than premiums received for reinsurance and for ocean marine insurance.

* * *

(d) The rate of the tax to be applied to the basis of the annual tax in respect to each year is 2.35 percent.

* * *

(h) The taxes provided for by this section shall be assessed by the State Board of Equalization.

(i) The Legislature, a majority of all the members elected to each of the two houses voting in favor thereof, may by law change the rate or rates of taxes herein imposed upon insurers.

(j) This section is not intended to and does not change the law as it has previously existed with respect to the meaning of the words "gross premiums, less return premiums, received" as used in this article.

California Revenue & Taxation Code, §§ 12201, 12221:

§ 12201.

Every insurer doing business in this State shall annually pay to the State a tax on the bases, at the rates, and subject to the

deductions from the tax hereinafter specified. For purposes of the tax imposed by this chapter, "insurer" shall be deemed to include a home protection company as defined in Section 12740 of the Insurance Code.

§ 12221.

In the case of an insurer not transacting title insurance in this State, the basis of the tax is, in respect to each year, the amount of gross premiums, less return premiums, received in such year by such insurer upon its business done in this State. "Gross premiums" do not include premiums received for reinsurance and for ocean marine insurance. Gross premiums of reciprocal or interinsurance exchanges shall be determined as provided in Section 1530 of the Insurance Code. For purposes of the tax imposed by this chapter, "gross premiums" shall be deemed to include home protection contract fees defined in Section 12740 of the Insurance Code.

APPENDIX B

[GROUP POLICY FORM OF THE METROPOLITAN LIFE INSURANCE COMPANY]

(Herein Called the Insurance Company)

Group Policy No. Specimen issued to

A. B. C. Company
(Herein Called the Employer)

In consideration of the payment by the Employer of the initial premium and of the payment hereafter by the Employer, during the continuance of this Policy, of all premiums when they fall due as hereinafter provided, the Insurance Company promises to make the payments herein provided, with respect to the Employees Insured hereunder, in accordance with and subject to the provisions of this Policy.

The provisions hereinafter contained are part of this Policy as fully as if recited over the signatures hereto affixed.

This Policy is issued for an initial period commencing with the date of issue and ending with the day immediately preceding January 1, 1959.

IN WITNESS WHEREOF, the Metropolitan Life Insurance Company has caused this Policy to be executed this third day of January 1958, to take effect as of the first day of January 1958, which last date is the date of issue hereof.

Secretary President

Registrar

Group Policy

Accident and Sickness Insurance (Weekly Benefit)
Insurance for Death or Dismemberment by
Accidental Means
Hospital Expense Insurance
Surgical Operation Insurance

Section 1. DEFINITIONS.—

(A) "Employee" means a full-time employee directly employed and compensated for services by the Employer.

(B) "Dependent" means (1) an Employee's wife, or (2) any unmarried child over fourteen days of age and under nineteen years of age of a male Employee, of a widowed female Employee, or of a female Employee whose husband is not an Employee, excluding in any case, (a) any person who is eligible for insurance as an Employee, (b) any person residing outside the United States and Canada, and (c), as to the Contributory Insurance, any person whose evidence of good health, furnished in accordance with the provisions of Section 3, is not accepted by the Insurance Company as satisfactory. The term "child" includes any legally adopted child, any stepchild who resides in the Employee's household, and any chi'd supported solely by the Employee and permanently residing in the household of which the Employee is the head.

(C) "Personal Insurance" means insurance providing benefits payable to an Employee on account of the happening of a specified event to the Employee.

(D) "Dependent Insurance" means insurance providing benefits payable to an Employee on account of the happening of a specified event to any of his Dependents.

(E) "Physician" or "surgeon" means a person legally licensed to practice medicine.

(F) "Hospital" means an institution operated for the care and treatment of sicknesses and injuries and having facilities for diagnostic, 24-hour nursing service, and, except in the case of a hospital primarily concerned with the treatment of chronic diseases, major surgery. The term "hospital" shall not include an establishment that is, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a nursing home, or a hotel.

(G) "Non-occupational injury" means any injury not arising out of or in the course of any employment for wage or profit.

(H) "Non-occupational sickness" means any sickness not entitling the person who has contracted the sickness to benefits under any workmen's compensation or occupational disease law.

(I) "Renewal date" means any January 1st following the date of issue of this Policy.

(J) "Due date" means the first day of any calendar month which begins after the date of issue of this Policy.

Section 2. ELIGIBILITY OF EMPLOYEES.—

Each employee employed on or prior to the date of issue of this Policy becomes eligible for Personal Insurance on the date of issue of this Policy. Each Employee employed subsequent to the date of issue of this Policy shall become eligible for Personal Insurance on the day immediately following the date of completion of three months of continuous service.

Each Employee shall become eligible for Dependent Insurance on the date he becomes eligible for Personal Insurance or the date the first person becomes a Dependent of such Employee, whichever date is later.

Section 3. EFFECTIVE DATES OF INSURANCE.—

(A) NON-CONTRIBUTORY INSURANCE (IF ANY)

(1) The Non-Contributory Personal Insurance on any Employee shall become effective on the date he becomes eligible for such insurance, provided he is then actively at work. The Personal Insurance on any Employee not actively at work on the day when his Personal Insurance would otherwise become effective shall become effective on the date of his return to active work.

(2) The Non-Contributory Dependent Insurance on any Employee shall become effective, with respect to those persons who are then Dependents of such Employee, on the date he becomes eligible for such Insurance, or on the effective date of his Personal Insurance, if later.

(3) The Non-Contributory Dependent Insurance with respect to any person who becomes a Dependent of an Employee while such Employee is Insured for Non-Contributory Dependent In-

surance shall become effective on the date such person becomes a Dependent of such Employee.

(B) CONTRIBUTORY INSURANCE (IF ANY)

(1) An Employee may become insured for Contributory Personal Insurance only by making written request to the Employer for such insurance on forms furnished by the Insurance Company.

(2) The Personal Insurance on any Employee who makes such request on or before the date he becomes eligible for such insurance shall become effective on the date he becomes eligible for such insurance, provided he is then actively at work.

(3) The Personal Insurance on any Employee who makes such request after the date he becomes eligible for such insurance and on or before the thirty-first day following the date he becomes eligible for such insurance, or on or before the thirty-first day following the date of his return to active work if he is not actively at work on the date he becomes eligible for such insurance, shall become effective, provided he is then actively at work, on the date of such request.

(4) Any Employee making such request after such thirty-first day and any Employee requesting reinstatement of his Personal Insurance after his Personal Insurance has ceased pursuant to Section 4 because of his failure to make the required contribution, must furnish at his own expense evidence of his insurability satisfactory to the Insurance Company before his Personal Insurance may become effective. The Personal Insurance on such Employee shall become effective, provided such Employee is then actively at work, on the first day of the calendar month next following the date the Insurance Company accepts such evidence of insurability as satisfactory.

(5) The Personal Insurance on any Employee not actively at work on the date when his Personal Insurance would otherwise become effective shall become effective on the dated of his return to active work.

(6) An Employee may become insured for Contributory Dependent Insurance only by making written request to the Em-

ployer for such insurance on forms furnished by the Insurance Company.

(7) The Dependent Insurance on any Employee who makes such request on or before the date he becomes eligible for such insurance shall become effective with respect to those persons who are then Dependents of such Employee, on the date he becomes eligible for such insurance, or on the effective date of such Employee's Personal Insurance, if later.

(8) The Dependent Insurance on any Employee who makes such request after the date he becomes eligible for such insurance and on or before the thirty-first day following the date he becomes eligible for such insurance, or on or before the thirty-first day following the date of his return to active work if he is not actively at work on the date he becomes eligible for such insurance, shall become effective, with respect to those persons who are then Dependents of such Employee, on the first day of the calendar month following the date of such request, or on the effective date of the Employee's Personal Insurance, if later.

(9) Any Employee making such request after such thirty-first day and any Employee requesting reinstatement of his Dependent Insurance after his Dependent Insurance has ceased pursuant to Section 4 because of his failure to make the required contributions, must furnish at his own expense evidence satisfactory to the Insurance Company of the good health of each person who is a Dependent of such Employee on the date of such request before the Dependent Insurance with respect to such Dependent may become effective. Any such insurance shall become effective with respect to each such Dependent whose evidence of good health is accepted by the Insurance Company as satisfactory, on the first day of the calendar month following the date of such acceptance by the Insurance Company, or on the effective date of the Employee's Personal Insurance, if later. In the event that the evidence of good health of any such person is not accepted by the Insurance Company as satisfactory, such person shall not, for the purposes of insurance hereunder, be deemed a Dependent and no Dependent Insurance shall be provided to such person.

(10) The Contributory Dependent Insurance with respect to any person who becomes a Dependent of an Employee while such Employee is insured for Contributory Dependent Insurance shall become effective on the date such person becomes a Dependent of such Employee.

(11) An Employee employed in Plant K may make written request for either (a) all types of insurance provided hereunder, or (b) all types of insurance provided hereunder exclusive of Surgical Operation Insurance. If any such Employee becomes insured for insurance as specified in (b) and subsequently desires to become insured for Surgical Operation Insurance, all the provisions of this subsection (B) shall be separately applicable with respect to the Surgical Operation Insurance.

Section 4. Cessation of Insurance.—

(1) The Personal Insurance and Dependent Insurance on any Employee insured hereunder shall automatically cease on whichever of the following dates first occurs:

(a) the last day of the calendar month in which termination of his employment occurs.

(b) the date of discontinuance of this Policy.

(2) If the Employee fails to make any contribution, as required, to the cost of his Contributory Personal Insurance, his Contributory Personal Insurance and Contributory Dependent Insurance shall automatically cease on the date of expiration of the last period for which the Employee made the required contribution.

(3) If the Employee fails to make any contribution, as required, to the cost of his Contributory Dependent Insurance, his Contributory Personal Insurance and Contributory Dependent Insurance shall automatically cease on the date of expiration of the last period for which the Employee made the required contribution.

(4) The Dependent Insurance on account of any Dependent shall automatically cease on the day immediately preceding the date such person ceases to be a Dependent of the Employee.

(5) Termination of employment, for the purposes of insurance hereunder, means cessation of active work as an Employee as defined in Section 1 hereof, except that in case of the absence of an Employee from active work because of sickness or injury, temporary lay-off or leave of absence, his employment may, for the purposes of his insurance hereunder, be deemed to continue until terminated by the Employer or by an act of the Employee but in the case of temporary lay-off or leave of absence, not beyond the expiration of a period of two months following the date such lay-off or leave of absence commenced.

(6) When an Employee is absent from active work and his employment is deemed to continue until terminated by the Employer or by an act of the Employee, employment shall be considered terminated by the Employer, if the Employer notifies the Insurance Company that the Employee is not to be included as an insured Employee, or if the Employer discontinues premium payment on account of such Employee.

Section 5. TYPES OF INSURANCE.—This Policy provides the following types of insurance in accordance with the provisions hereof and of the forms specified, which forms are part of this Policy.

Type of Insurance	Form
Accident and Sickness Insurance	G.2230-4
Insurance for Death or Dismemberment by Accidental Means	G.2235-4
Hospital Expense Insurance Personal and Dependent Benefits	G.2240-4
Surgical Operation Insurance Personal and Dependent Benefits	G.2244-4

Section 6. COMPUTATION AND PAYMENT OF PREMIUMS; GRACE PERIOD.—

(1) The premiums due on and after the date of issue of this Policy for the insurance provided hereunder shall be determined and shall be payable in accordance with the following paragraphs.

(2) The initial premium is due on the date of issue of this Policy and subsequent premiums shall be due on each due date thereafter.

(3) The initial premium rates for the insurance provided hereunder are shown in the respective riders attached hereto. The Insurance Company may change any or all of such premium rates (a) on the first renewal date of this Policy and on any due date thereafter, or (b) whenever the terms of this Policy are changed, provided that in the case of any increase in the premium rates, except when the terms of the Policy are changed, the Insurance Company shall deliver to the Employer written notice of such increase at least thirty-one days prior to the date such increase is to become effective.

(4) The initial premium due on the date of issue of this Policy and the premium due on any due date after the date of issue of this Policy shall be the aggregate of the premiums for the insurance then in force, determined on the basis of the premium rates then in effect for the respective types of insurance, subject to premium adjustments, if any.

(5) In the computation of the aggregate premium due under this Policy on any due date, the Inusrance Company may use any equitable method which is mutually agreeable to the Employer and the Insurance Company.

(6) Premium adjustments involving return of unearned premiums to the Employer shall be limited to the period of twelve months immediately preceding the date of receipt by the Insurance Company of evidence that such adjustments should be made.

(7) On written request of the Employer, approved by the Insurance Company, premium payments may, if not then so payable, be changed at any due date of this Policy so as to be payable annually, semi-annually, quarterly, or monthly.

(8) All premiums falling due under this Policy, including adjustments thereof, if any, are payable by the Employer, on or before their respective due dates, directly to the Insurance Company at its Home Office or one of its Head Offices. The payment of any premium shall not maintain the insurance under this Policy in force beyond the day immediately preceding the next due date, except as provided in the next paragraph.

(9) Grace Period.—A grace period of thirty-one days will be granted for the payment of premiums accruing after the first premium, during which grace period this Policy shall continue in force, but the Employer shall be liable to the Insurance Company for the payment of the premium accruing for the period the Policy continues in force.

(10) If the Employer fails to pay any premium within the grace period, this Policy shall be discontinued on the last day of such grace period, except that if written notice is given by the Employer to the Insurance Company prior to the expiration of the grace period that this Policy is to be discontinued before the expiration of the grace period, this Policy shall be discontinued as of the date of receipt of such written notice by the Insurance Company or the date specified by the Employer for such discontinuance, whichever date is later, and the Employer shall be liable to the Insurance Company for the payment of the pro-rata premium for the period commencing with the last due date and ending with such date of discontinuance.

Section 7. CERTIFICATES.—The Insurance Company will issue to the Employer, for delivery to each Employer insured hereunder, an individual certificate which shall state the insurance to which such Employee is entitled under this Policy and to whom benefits are payable, and which shall summarize the provisions of this Policy principally affecting the Employee. The word "certificate" as used in this Policy includes certificate riders and certificate supplements, if any.

Section 8. ASSIGNMENT.—The Employee's certificate is non-assignable and the insurance and benefits are non-assignable prior to a loss.

Section 9. RECORDS; INFORMATION TO BE FURNISHED.—The Insurance Company shall maintain records from which may be determined at all times the names of all Employees insured hereunder and the amount of insurance in force on each of such Employees, together with the date when any insurance became effective and the effective date of any increase or decrease in amount of insurance. Such records may, with the

consent of the Insurance Company, be maintained by the Employer.

The Employer and the Employees shall furnish to the Insurance Company all information which the Insurance Company may reasonably require with regard to any matters pertaining to the insurance under this Policy. The Employer agrees to allow the Insurance Company to inspect all documents, books, and records of the Employer which may have a bearing on the insurance or premiums under this Policy.

Section 10. PARTICIPATION; DIVIDENDS.—This Policy is a participating contract and the Insurance Company shall determine annually the dividend, if any, to which this Policy may be entitled. Any such dividend shall be paid in cash to the Employer or, upon written request by the Employer, shall be applied toward the payment of premiums. The Employer may apply any dividend to reduce the Employer's cost of this Policy, except that an amount equal to the excess, if any, of the Employee's aggregate contributions toward the cost of the insurance provided hereunder over the net cost of such insurance shall be distributed or applied by the Employer for the sole benefit of the Employees.

Section 11. RENEWAL PRIVILEGE.—This Policy may be renewed on any renewal date for a further period ending with the day immediately preceding the next renewal date, provided that the Insurance Company may decline to renew this Policy on any renewal date (a) if the number of Employees then insured for Contributory Insurance is less than 75% of the number of Employees eligible for such insurance, (b) if the number of Employees then insured for Non-Contributory Insurance is less than the total number of Employees eligible for such insurance, or (c) if the number of Employees then insured hereunder is less than twenty-five. Renewal is conditioned upon the payment of the premiums then due as computed in the manner set forth in Section 6 and based upon such premium rates as may then be determined by the Insurance Company.

Section 12. ENTIRE CONTRACT; CHANGES.—This Policy and the application of the Employer constitute the entire

contract between the parties, and any statement made by the Employer or by any Employee shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall avoid the insurance or reduce the benefits under this Policy or be used in defense to a claim hereunder unless it is contained in a written application, nor shall any such statement of the Employer, except a fraudulent misstatement, be used at all to void this Policy after it has been in force for three years from the date of its issue, nor shall any such statement of any Employee eligible for coverage under the Policy, except a fraudulent misstatement, be used at all in defense to a claim for loss incurred or disability (as defined in the Policy) commencing after the insurance coverage with respect to which claim is made has been in effect for three years from the date it became effective.

No change in this Policy shall be valid unless approved by an executive officer of the Insurance Company and evidenced by endorsement hereon, or by amendment hereto signed by the Employer and by an executive officer of the Insurance Company. No agent has authority to change this Policy or to waive any of its provisions.

Section 13. ADDITIONAL PROVISIONS.—This Policy is not in lieu of and does not affect any requirement for coverage by workmen's compensation insurance.

APPLICATION TO THE METROPOLITAN LIFE INSURANCE COMPANY FOR GROUP INSURANCE

A.B.C. COMPANY
(*Name of Employer*)
100 Main Street, Doeville, California
(*Address where Policy is to be delivered and from which premiums are to be paid*)

The word "Employee", as used herein, means a full-time employee directly employed and compensated for services by the Employer.

Forms of Group Insurance desired are:

	For Employees Only	For Employees and Dependents
Life Insurance	☐	☐
Accident and Health Insurance	☒	☐
Insurance for Death or Dismemberment by Accidental Means	☒	☐
Hospital Expense Insurance	☐	☒
Surgical Operations Insurance	☐	☒
Supplementary Hospital Benefits for Physicians' Attendance	☐	☐
Insurance for Physicians' Attendance Expense While in Hospital	☐	☐
Medical Expense Insurance	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Premiums will be paid Monthly ☒, _____ly ☐. Advance payment of $100.00 accompanies this application.

It is agreed that:

(a) The conditions of eligibility for insurance, the amounts of insurance, the conditions under which insurance will be payable and other contractual terms shall be in accordance with the Policy (or Policies) issued.

(b) The Group Policy (or Policies) shall become effective provided:

(1) This application is accepted by the Metropolitan Life Insurance Company at its Home Office or one of its Head Offices.

(2) At least 25 Employees are to be insured on the date of issue thereof.

(3) If the Employees are to contribute toward the cost, at least 75% of all eligible Employees make written requests for insurance thereunder and if insurance for Dependents is applied for and Employees are required to contribute to the cost thereof, at least 75% of all Employees eligible for such insurance make written request therefor, and

(4) An amount equal to the initial premium as estimated by the Insurance Company has been received by the Insurance Company.

(c) The Employer shall furnish the Insurance Company each month with the necessary particulars concerning employees to be insured on or subsequent to the date of issue of the Policy (or Policies), and on employees whose insurance is to be changed or discontinued.

(d) The Group Policy (or Policies) applied for will not be in addition to nor replace any other insurance on the Group or similar plan except as follows: x x x x x x

Dated at Doeville, California this first day of January, 1958

A.B.C. COMPANY
(*Employer*)

JAMES SMITH (*Witness*) By RICHARD ROE PRESIDENT (*Title*)

COPY OF EMPLOYER'S APPLICATION
ATTACHED HERETO

NOTICES TO POLICYHOLDERS

PRIVILEGE OF VOTING FOR DIRECTORS. An election of Directors of the Insurance Company is held in New York on the second Tuesday in April of every odd-numbered year. The holder of this Policy (the Employer), after one year from its date of issue, while it remains in force, will have a right to vote either in person or by proxy or by mail. For particulars as to how to vote, apply to the Secretary, 1 Madison Avenue, New York, N.Y.

NOMINATIONS FOR DIRECTORS. Section 198 of the New York Insurance Law requires the Board of Directors to nominate candidates described as the "Administration Ticket" and permits groups of policyholders to make other nominations not less than five months prior to the election.

METROPOLITAN LIFE INSURANCE COMPANY

HOME OFFICE	HEAD OFFICES	
1 Madison Avenue	600 Stockton Street	180 Wellington Street
New York, New York	San Francisco, California	Ottawa, Ontario, Canada

Countersigned January 3, 1958

By Richard Roe
Licensed Agent

Employer: A. B. C. Company

Group Policy No. Specimen Effective Date of Rider: January 1, 1958

Group Accident and Sickness Insurance Rider
Personal Benefits

Issued By

Metropolitan Life Insurance Company
(Herein called the Insurance Company)

Section H-1. Insuring Clause.—Upon receipt by the Insurance Company of notice and due proof, as required herein, that any Employee while insured hereunder shall have become wholly and continuously disabled so as to be prevented from performing any and every duty of his occupation as a result of non-occupational injury or non-occupational sickness and that during the period of such disability such Employee shall have been under treatment therefor by a physician or surgeon, the Insurance Company shall pay to such disabled Employee, subject to the terms and limitations hereof, the Weekly Benefits applicable to him in accordance with Section H-2 hereof, during the period the Employee is so disabled and under such treatment, provided that

(i) in no case shall such Weekly Benefits be payable for the Waiting Period, and

(ii) in no case shall such Weekly Benefits be payable for more than the Maximum Benefit Period.

The Waiting Period and Maximum Benefit Period referred to above shall be applicable to any one continuous period of disability whether from one or more causes.

Successive periods of disability due to the same or related cause or causes shall be considered one continuous period of disability unless, between such periods of disability, the Employee was actively at work as an Employee for at least three months.

No payment shall be made for any period during which the Employee engages in any gainful occupation.

For disability caused by any one pregnancy or resulting childbirth or complications, not more than six weeks' benefits shall be paid; provided that if the date the Employee became insured is on or subsequent to February 2, 1958, no benefits shall be paid for such diability commencing within nine months after the date she became insured unless affirmative proof is submitted to the Insurance Company that the pregnancy commenced after the date she became insured.

For all periods of disability commencing on or after the Employee's sixtieth birthday and within any twelve consecutive months, Weekly Benefits shall not be payable for more than the Maximum Benefit Period applicable to the Employee.

The Accident and Sickness Insurance on any Employee shall automatically cease upon the expiration of the Maximum Benefit Period applicable to him. Such insurance may be reinstated only if and when the Employee returns to active work as an Employee on full time.

Section H-2. SCHEDULE OF INSURANCE AND INITIAL PREMIUM RATES.—The insurance applicable to any Employee shall be in accordance with the schedule set forth below and any change in accordance with such schedule shall become effective, provided the Employee is then actively at work, on the date of change in the Employee's classification; if the Employee is not then actively at work, such change shall become effective on the date of his return to active work.

	Weekly Benefit	Waiting Period for Disability Due to Injury	Waiting Period for Disability Due to Sickness	Maximum Benefit Period	Initial Monthly Premium Rate per Employee
		NON-CONTRIBUTORY INSURANCE			
All Employees	$10.00	No Waiting Peirod	First Seven Days*	Twenty-six Weeks	$0.66
		CONTRIBUTORY INSURANCE			
Employees with basis annual rate of earnings (as determined by the Employer) of:					
Less than $3,000.00	20.00				1.32
$3,000.00 but less than $4,000.00	30.00	No Waiting Period	First Seven Days*	Thirteen Weeks	1.98
4,000.00 but less than 6,000.00	40.00				2.64
6,000.00 but less than 8,000.00	50.00				3.30
8,000.00 or more	60.00				3.96

* or the period of disability prior to confinement in a hospital as a registered bed patient if such confinement commences prior to the expiration of the Waiting Period otherwise applicable.

No Employee shall contribute to the cost of his Contributory Insurance more than the premium for such insurance. No Employee shall contribute to the cost of his Non-Contributory Insurance.

Section H-3. NOTICE OF CLAIM.—Written notice of claim must be given to the Insurance Company within twenty days after the occurrence or commencement of any loss covered by this Rider, or as soon thereafter as is reasonably possible.

Section H-4. CLAIM FORMS.—The Insurance Company, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this Rider as to proof of loss upon submitting, within the time fixed in this Rider for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Section H-5. PROOFS OF LOSS.—Written proof of loss for which a claim for Weekly Benefits is made must be furnished to the Insurance Company within ninety days after the termination of the period for which the Insurance Company is liable. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Employee, later than one year from the time proof is otherwise required.

Section H-6. TIME OF PAYMENT OF CLAIM.—Subject to due written proof of loss, all accrued indemnity for loss for which this Rider provides Weekly Benefits will be paid to the insured Employee weekly and any balance remaining unpaid at the termination of the period of liability will be paid immediately upon receipt of due written proof.

Section H-7. PHYSICAL EXAMINATION.—The Insurance Company at its own expense shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of a claim when and as often as it may reasonably require during pendency of a claim hereunder.

Section H-8. LEGAL ACTIONS.—No action at law or in equity shall be brought to recover on this Rider prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this Rider. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

IN WITNESS WHEREOF, the Metropolitan Life Insurance Company has caused this Rider to be executed to take effect as of the effective date of the Rider as indicated on the first page hereof.

Secretary President

[The "Group Insurance for Death or Dismemberment By Accidental Means Rider (Personal Benefits)" and the "Group Hospital Expense Insurance Rider (Personal and Dependent Benefits)", comprising pages 1219 through 1227 of Appellants' Excerpt of Record on file with the Court of Appeals, is deleted for purposes of this Appendix.]

Employer: A. B. C. Company

Group Policy No. Specimen Effective Date of Rider: January 1, 1958

Group Surgical Operation Insurance Rider
Personal and Dependent Benefits

Issued By

Metropolitan Life Insurance Company
(Herein called the Insurance Company)

Section S-1. INSURING CLAUSE.—Upon receipt of due proof, as required herein, that any Employee, while insured hereunder for Surgical Operation Insurance on his own account, or any Dependent of an Employee, while such Employee is insured hereunder for Surgical Operation Insurance on account of such Dependent, shall have undergone a surgical operation as a result of non-occupational injury or non-occupational sickness, the Insurance Company shall pay, subject to the terms and limitations hereof, an amount equal to the actual surgical fee charged for such surgical operation, provided (1) that such surgical operation was recommended and performed by a physician or surgeon, and (2) that the amount of such payment shall in no event exceed the maximum payment for such surgical operation determined in accordance with Section S-3 hereof.

If two or more surgical operations are performed upon an Employee or Dependent at the same time, or if two or more surgical operations due to the same or related cause or causes are performed upon an Employee or Dependent at different times, the total payment hereunder for all such operations shall not exceed the Maximum Surgical Operation Benefit in force hereunder on account of such Employee or Dependent who has undergone such operations, as determined by Section S-2 hereof, subject to any limitations set forth in Section S-3 hereof. Operations performed on an Employee and separated by a period of at least three months of active work as Employee, or operations performed on a Dependent and separated by a period of at least three months of normal activity by the Dependent, shall not be considered due to the same or related cause or causes.

In the case of a female Employee becoming insured on or subsequent to February 2, 1958, no payment shall be made for a surgical operation performed on the Employee within nine months after the date the Employee became insured if the surgical operation is caused by pregnancy or resulting childbirth or complications unless affirmative proof is submitted to the Insurance Company that the pregnancy commenced after the date the Employee became insured.

No payment shall be made for a surgical operation performed on a Dependent within nine months after the date the Employee became insured on account of such Dependent if the surgical operation is caused by pregnancy or resulting childbirth or complications, unless affirmative proof is submitted to the Insurance Company that the pregnancy commenced after the date the Employee became insured on account of the Dependent.

Benefits hereunder are not payable for any surgical operation which is or may be obtained without cost to a person covered hereunder, in accordance with laws or regulations of any government. If a charge is made to any such person which he is legally required to pay, any benefits hereunder will be computed in accordance with the provisions hereof, taking into account only such charge. "Any government" includes the Federal, State, Provincial or local government or any political subdivision thereof, of the United States or Canada.

An Employee's Surgical Operation Insurance on his own account shall automatically cease on the date he becomes entitled to the Maximum Surgical Operation Benefit applicable to him. Such insurance may be reinstated only if and when the Employee returns to active work as an Employee on full time.

An Employee's Surgical Operation Insurance on account of any Dependent shall automatically cease on the date the Employee becomes entitled to the Maximum Surgical Operation Benefit applicable to such Dependent. Such insurance may be reinstated only after recovery of the Dependent from the injury or sickness which necessitated a surgical operation for which benefits were payable.

Section S-2. SCHEDULE OF INSURANCE AND INITIAL PREMIUM RATES.—The insurance applicable to any Employee shall be in accordance with the schedule set forth below and any change in accordance with such schedule shall become effective, provided the Employee is then actively at work, on the date of change in the Employee's classification; if the Employee is not then actively at work, such change shall become effective on the date of his return to active work.

	Maximum Surgical Operation Benefit		Initial Monthly Premium Rate per Employee			
				Dependent Insurance		
	Employee	Dependent	Personal Insurance	Child or Children Only	Wife Only	Wife and Child or Children
NON-CONTRIBUTORY INSURANCE						
Employees at Plant A....	$250	$250	$0.72	$1.00	$1.70	$2.70
All other Employees.....	No Insurance		—	—	—	—
CONTRIBUTORY INSURANCE						
Employees at Plant A....	No Insurance		—	—	—	—
All other Employees.....	$350	$300	$1.01	$1.20	$2.04	$3.24

No Employee shall contribute to the cost of his Contributory Insurance more than the premium for such insurance. No Employee shall contribute to the cost of his Non-Contributory Insurance.

[Section S-3. MAXIMUM PAYMENTS FOR SURGICAL OPERATIONS.—The] payment for any surgical operation shall not exceed the amount specified for such surgical operation in the following Schedule. If the Maximum Surgical Operation Benefit in force hereunder on account of an Employee or Dependent is other than $250, the amount specified for a surgical operation or surgical operations shall be multiplied by the ratio which the Maximum Surgical Operation Benefit in force hereunder on account of the Employee or Dependent who undergoes such operation or operations bears to $250.

If more than one operation is performed through the same abdominal incision, the total payment for all such operations shall not exceed the greater of $175.00 or the maximum payment specified in the schedule for that one of such operations for which the largest amount is payable.

Surgical Operation	Maximum Payment
[Listings for "Abdomen." "Amputations," "Bones," "Breast," "Cardiovascular System," "Chest," "Dislocations, Reduction of," "Ear, Nose or Throat," "Endoscopic Procedures," and "Eye" are deleted for purposes of this Appendix.]	
Fractures, Treatment of:	
Unless otherwise specified the maximum payment is the payment for closed reduction or treatment. Maximum payment for open reduction or operation for treatment of compound fractures is twice the amount shown for closed reduction unless otherwise specified in the schedule but not exceeding $250.00.	
Epiphysial separations are considered fractures of the bone involved.	
Skull	
Depressed:	
Requiring dural repair	$ 250.00
Not requiring dural repair	125.00
Non-operative treatment	50.00
Facial Bones	
Nose	25.00
Mandible, or maxilla	50.00
Mandible, or maxilla open or closed reduction, with wiring of teeth or application of skeletal fixation	150.00
Facial bones (not otherwise classified)	25.00
Spine and Trunk	
Vertebra, body of: closed treatment (one or more)	100.00
laminectomy or spine fusion for	250.00
Vertebral process, one or more	25.00

Surgical Operation	Maximum Payment
Sacrum	50.00
Coccyx	25.00
Ribs: one	20.00
each additional	5.00
Sternum	25.00
Sternum, depressed-open reduction	100.00
Clavicle	40.00
Scapula	50.00
Pelvis:	
Closed reduction	75.00
With fracture and protrusion of the acetabulum	125.00
Open operation including repair of pelvic contents	250.00
Upper Extremity	
Humerus	100.00
Elbow, fracture into	100.00
Radius and/or ulna	100.000
Wrist: Carpal Bones—one or more	75.00
Metacarpal—one or more	50.00
Finger or thumb: one	30.00
each additional	10.00
Lower Extremity	
Femur	175.00
Tibia and/or fibula	125.00
Patella	65.00
Ankle, bimalleolar or trimalleolar	125.00
Astragalus and/or Os Calcis	100.00
Other Tarsal and/or Metatarsal bones	50.00
Toes: one	30.00
each additional	10.00

[Listings for "Genital System," "Hernia," "Joints," "Muscles—Cutting, Repairs, Suturing and Transplantation," "Nerves," "Obstetrical Procedures," "Paracentisis," "Rectum and Anus," "Skin and Subcutaneous Areolar Tissue," "Skull," "Spine", "Tendons," "Thyroidectomy," "Tumors," and "Urinary System" are deleted for purposes of this Appendix.]

The maximum payment for any surgical operation not specified in the above schedule shall be determined by the Insurance Company on the basis of the severity of the type of operation, in an amount consistent with the maximum payments for operations listed.

If Surgical Operation Insurance Benefits are paid hereunder for a surgical operation performed outside of a legally constituted

hospital while Hospital Expense Insurance under said Group Policy is in force on account of the person who underwent such operation, the Insurance Company shall pay, in addition to the payments otherwise provided, the amount of the actual expense, if any, charged for a general anesthesia and the administration thereof in connection with such operation up to a maximum of $10.

Section S-4. PAYMENT OF CLAIMS.—All benefits provided in this Rider shall be paid to the Employee as they accrue upon receipt of written proof covering the occurrence, character and extent of the event for which claim is made.

Section S-5. SURGICAL OPERATION PERFORMED AFTER CESSATION OF INSURANCE.—If any Employee or Dependent, at the date of cessation of the Surgical Operation Insurance on his account, is totally disabled as a result of injury or sickness and, while still so totally disabled and within thirty-one days after such cessation, undergoes a surgical operation, the Employee will be entitled to whatever benefits would have been payable hereunder in consequence of such surgical operation had such Surgical Operation Insurance continued in force without change to the date of such surgical operation.

If a female Employee or Dependent is pregnant at the date of the cessation of the Surgical Operation Insurance hereunder on her account and, as a result of such pregnancy and within nine months after such cessation, undergoes a surgical operation, the Employee will be entitled to whatever benefits would have been payable hereunder in consequence of such surgical operation had such Surgical Operation Insurance continued in force without change to the date of such surgical operation.

IN WITNESS WHEREOF, the Metropolitan Life Insurance Company has caused this Rider to be executed to take effect as of the effective date of the Rider as indicated on the first page hereof.

Secretary President

APPENDIX C

This Agreement by and between

GENERAL MOTORS CORPORATION
(Herein called the Employer)

and

METROPOLITAN LIFE INSURANCE COMPANY
(Herein called the Insurance Company),

WITNESSETH:

WHEREAS, the Employer is the holder of the Group Policies issued by the Insurance Company and listed in the following table (herein called the Group Policies) under which certain kinds of insurance, listed in said table for each such Group Policy as being subject to this Agreement, are provided for certain eligible Employees, as defined herein,

TABLE

Group Policy No.	Bearing Date of	Kinds of Insurance Subject to This Agreement
		The following kinds of insurance for Employees employed in the United States except for such insurance on (i) Employees who reside in the State of Connecticut, (ii) Employees who are employed in the State of California, and (iii) Surviving Spouses who contribute to the cost of the insurance on their own account and the insurance, if any, on account of their Dependents an amount equal to the premiums charged for such insurance.
22400-G	October 1, 1964	Surgical and Medical Expense Insurance, Hospital Expense Insurance and Prescription Drug Expense Insurance
24041-G	October 1, 1974	Vision Care Expense Insurance
24042-G	August 1, 1975	Comprehensive Medical Expense Insurance and Maternity Benefits

and WHEREAS, the Employer has established its Insurance Programs for Hourly-Rate and Salaried Employees (hereinafter referred to as the "Plan") providing benefits for certain Employees equivalent to those that would be payable under the kinds of insurance listed in said table, under which Plan the Employer will arrange to pay the benefits to which such Employees become entitled, and

WHEREAS, the Employer desires the Insurance Company to pay in any policy month, only those benefits becoming due under the Plan as are in excess of a stated aggregate amount paid by the Employer in such policy month, and

WHEREAS, the Insurance Company is willing to provide insurance under the Group Policies for that purpose,

NOW THEREFORE, it is agreed as follows:

(1) This Agreement and its provisions shall be attached to and become a part of each of the Group Policies and shall be effective January 1, 1976.

(2) The provisions of each of the Group Policies that apply to the kinds of insurance subject to this Agreement are modified to the extent set out in this Agreement, and to that extent the provisions of this Agreement shall govern notwithstanding anything in any of the Group Policies to the contrary.

(3) The provisions of this Agreement shall apply with respect to the Employees insured under each of the Group Policies for the kinds of insurance subject to this Agreement.

(4) While this Agreement remains in effect, the Insurance Company shall have the obligation to pay benefits otherwise expressed to be payable under the terms of the Group Policies, with respect to Employees whose insurance under the Group Policies is subject to this Agreement,

(a) during the first policy month in which this Agreement is in effect, and

(b) during any subsequent policy month only if and when the Employer has had paid from its funds benefits under the Plan during such policy month in an Aggregate Amount

determined in accordance with the provisions of the following paragraph (5),

and the Insurance Company shall have the obligation to pay from its funds such benefits only during the remainder of that policy month and during the remainder of any other such policy month. The Insurance Company shall also pay any benefits due which are the obligation of the Employer in accordance with paragraph (5) hereof but which are not paid from the Employer's funds, subject to reimbursement in accordance with paragraph (7) hereof.

(5) The point in time, if any, in each policy month, at which the Insurance Company's obligation to pay benefits from its funds shall commence, as stated in paragraph (4) above, shall be when the Employer shall have had paid from its funds during such policy month, in accordance with the Plan, benefits described in the following paragraph (6) on account of Employees covered under the Plan whose insurance under the Group Policies is subject to this Agreement, in an Aggregate Amount determined for that policy month in accordance with the following sentences. For the policy month in which this Agreement becomes effective and for the first policy month of each succeeding policy year, the Aggregate Amount is

$29.87 times the number of Employees reported by the Employer to be covered by the Group Policies for determining premiums for that policy month.

For each other policy month, the Aggregate Amount is the sum of

(a) $29.87 times the number of Employees reported by the Employer to be covered by the Group Policies for determining premiums for that policy month, and

(b) the amount, if any, by which the Aggregate Amount for the preceding policy month exceeds the benefits paid from the Employer's funds for such preceding policy month.

The Aggregate Amount for any policy month may be changed by agreement between the Employer and the Insurance Company.

(6) The benefits payable from the Employer's funds in each policy month, in accordance with the Plan, as referred to in paragraph (5) above, are as follows:

(a) Benefits with respect to all claims under the Plan for losses originating on or after the first day of that policy month, and

(b) Benefits with respect to claims under the Group Policies for losses originating prior to the first day of that policy month if such benefits were not paid prior to the first day of that policy month, it being expressly understood and agreed (i) that the amount of such benefit payments made from the Employer's funds shall be included with those specified in the preceding item (a) for the purpose of determining when the Insurance Company's obligation to pay benefits under the Group Policies, as hereby amended, shall commence in any policy month as stated in paragraph (5) above, and (ii) that the Insurance Company shall not reimburse the Employer for any such payments made from the Employer's funds other than for payments made during a period when the Insurance Company has the obligation to pay benefits under the terms of this Agreement.

(7) If any amount of benefits shall have been paid from the Employer's funds and such amount was an obligation of the Insurance Company pursuant to this Agreement, the Insurance Company shall reimburse the Employer for such payment. If the Insurance Company shall have paid from its funds any amount of benefit which was not an obligation of the Insurance Company pursuant to this Agreement the Employer shall reimburse the Insurance Company for such payment.

(8) The Insurance Company shall have the right to make final determination of the amount of benefits, if any, to which an Employee shall be entitled in any claim for benefits accruing under the Employer's Plan during any period in which the Insurance Company is not obligated to pay benefits from its funds pursuant to this Agreement, and the Employer agrees to accept and follow such determination in having such benefits paid from its funds pursuant to the Plan. Such determination shall be made

by the Insurance Company on the same basis used to determine entitlement to benefits during a period in which the Insurance Company is obligated to pay benefits from its funds pursuant to this Agreement. If the Insurance Company so determines that any claim shall be rejected and if any suit shall be brought with respect to such a claim, the Insurance Company agrees to undertake at its expense the defense of such suit and to pay any judgment rendered therein. The Insurance Company shall, however, have the right to settle any such suit when in its judgment it appears expedient to do so. If any such judgment or settlement is paid from the Insurance Company's funds during a period in which the Insurance Company is not obligated to pay benefits pursuant to this Agreement, the Employer shall reimburse the Insurance Company for the amount of benefit payments included in such judgment or settlement.

(9) In no case shall the Insurance Company be liable for the benefits payable from the Employer's funds, in accordance with the Plan, as stated in paragraph (6) hereof, nor shall the Employer be liable in any case for the benefits payable from the Insurance Company's funds under paragraph (4) and (13) hereof, it being agreed that the payments from the funds of the Employer as stated in paragraph (6) hereof, and of the Insurance Company pursuant to this Agreement, are and shall be mutually exclusive.

(10) The term "policy year" as used in these provisions means the period beginning with a renewal date of the Group Policies and ending with the day immediately preceding the next following renewal date or, unless the Insurance Company and the Employer shall agree otherwise, with the date of discontinuance of any of the Group Policies if prior thereto. The term "policy month" means the period beginning with a premium due date of the Group Policies and ending with the day immediately preceding the next premium due date. For the purposes of this Agreement, a loss originates upon the happening of an event for which benefits may be claimed; benefits become due upon receipt by the Employer or the Insurance Company of due proof in substantiation of a valid claim for such benefits.

(11) Instead of the method of computation of the premiums due under the Group Policies for the insurance subject to this Agreement, as set forth in the provisions of the Group Policies which relate to the computation of premiums thereunder, the Insurance Company shall determine for that purpose an aggregate average monthly premium rate for all such insurance to which this Agreement is applicable. The monthly premium rate for such insurance for the first policy year this Agreement is in effect, subject to the rights of the Insurance Company to change premium rates as specified in the Group Policies, shall be $5.30 per Employee reported by the Employer to be covered by the Group Policies for determining premiums or such other rate as may be agreed upon between the Insurance Company and the Employer. In addition to the premium, if any, otherwise due for the insurance under the Group Policies which is subject to this Agreement, an additional monthly premium shall be due and payable to the Insurance Company for the last month that this Agreement is in effect; such additional premium shall be equal to the excess of

(a) The total amount of premiums, as determined by the Insurance Company, which would have been payable since the end of the preceding policy year if this Agreement had not been in effect, over

(b) The sum of

(i) the premiums actually paid to the Insurance Company for the period from the end of the preceding policy year, and

(ii) the claims paid from the Employer's funds since the end of the first month of the then current policy year.

In addition to any other rights to change premium rates, the Insurance Company shall also have the right to change any or all premium rates if and when this Agreement is discontinued or the Employer modifies the Plan. In all other respects the provisions of the Group Policies which concern the due date, computation and payment of premiums thereunder shall continue unchanged by this Agreement.

(12) The Employer agrees to furnish the Insurance Company with all information which it may from time to time request for the purpose of carrying out the terms of this Agreement.

(13) This Agreement may be discontinued by the Insurance Company or by the Employer as of the day preceding any premium due date by giving written notice thereof to the other party at least 60 days prior to such date of discontinuance. This Agreement shall automatically be discontinued as of the earliest of the following dates:

(i) The last day of the policy month for which the Employer shall not have made funds available for the payment of all benefits stated to be payable from his funds in accordance with this Agreement.

(ii) The date as of which any of the Group Policies is discontinued, whether by written notice or cessation of premium payments.

Upon discontinuance of this Agreement the Insurance Company shall have the obligation to pay all benefits, if any, with respect to all insurance under the Group Policies which is subject to this Agreement, that become due in accordance with the provisions of the Group Policies after the date of discontinuance of this Agreement. Unless another arrangement satisfactory to the Insurance Company and the Employer is made, however, discontinuance of this Agreement for any reason shall not terminate the application of its provisions with respect to any benefits which became due prior to the date of such discontinuance.

IN WITNESS WHEREOF, the Employer and the Insurance Company have caused this Agreement to be executed by their respective officers duly authorized so to do.

At Detroit, Michigan this 5th day of June 1978.

Attest:

GENERAL MOTORS CORPORATION

Title: D.W. Schneider, Director
Employee/Benefit Plans
Administration

Title: R.M. Cone, Director
Insurance and
Pension Section

At New York, New York this 12th day of February 1979.

Attest:

METROPOLITAN LIFE INSURANCE COMPANY

GEORGE V. RICHARDSON
Title:

By ROBERT C. HOFFMAN
Title:

FORM G.9372

METROPOLITAN LIFE INSURANCE COMPANY

Agreement Form G.9372, entered into by and between GENERAL MOTORS CORPORATION and Metropolitan Life Insurance Company effective January 1, 1976, is hereby amended, as follows:

I. Effective July 1, 1977, by adding to the introduction to the kinds of insurance subject to said Agreement Form G.9372, the following:

", and except for Vision Care Expense Insurance on employees who are not hourly-rate employees in a bargaining unit for which International Union of Electrical, Radio and Machine Workers and one of its local unions is the duly certified collective bargaining representative."

II. Effective October 1, 1977, by substituting for the Table appearing in said Agreement Form G.9372, the following:

TABLE

Group Policy No.	Bearing Date of	Kinds of Insurance Subject to this Agreement
		The following kinds of insurance for Employees employed in the United States except for such insurance on (i) Employees who reside in the State of Connecticut, (ii) Employees who are employed in the State of California, and (iii) Surviving Spouses who contribute to the cost of the insurance on their own account and the insurance, if any, on account of their Dependents an amount equal to the premiums charged for such insurance, and except for Vision Care Expense Insurance on employees who are not hourly-rate employees in a bargaining unit for which International Union of Electrical, Radio and Machine Workers and one of its local unions is the duly certified collective bargaining representative
22400-G	October 1, 1964	Surgical and Medical Expense Insurance, Hospital Expense Insurance, Prescription Drug Expense Insurance and Hearing Aid Expense Insurance
24041-G	October 1, 1974	Vision Care Expense Insurance
24042-G	August 1, 1975	Comprehensive Medical Expense Insurance and Maternity Benefits

III. Effective January 1, 1978, by deleting from the Table in said Agreement Form G.9372, the following:

TABLE

Group Policy No.	Bearing Date of	Kinds of Insurance Subject to this Agreement
24041-G	October 1, 1974	Vision Care Expense Insurance

IV. Effective May 1, 1979, by substituting for the Table appearing in said Agreement Form G.9372, the following:

TABLE

Group Policy No.	Bearing Date of	Kinds of Insurance Subject to this Agreement
		The following kinds of insurance for Employees employed in the United States except for such insurance on Surviving Spouses who contribute to the cost of the insurance on their own account and the insurance, if any, on account of their Dependents an amount equal to the premiums charged for such insurance
22400-G	October 1, 1964	Surgical and Medical Expense Insurance, Hospital Expense Insurance, Prescription Drug Expense Insurance and Hearing Aid Expense Insurance
24042-G	August 1, 1975	Comprehensive Medical Expense Insurance and Maternity Benefits

The foregoing amendment is to be attached to and made part of each of the Group Policies, and is subject to the agreements and covenants therein contained.

Dated at Detroit, Michigan, this 12th day of January, 1983.

R. D. Anderson
(Witness)

GENERAL MOTORS CORPORATION
(Employer)

By R. L. SHERMAN

(SPACE BELOW FOR USE OF METROPOLITAN LIFE INSURANCE COMPANY ONLY)

Dated at New York, New York, this 14th day of January, 1983.

George L. Richardson
(Registrar)

METROPOLITAN LIFE
INSURANCE COMPANY

Harry P. Kamen
Secretary

Form 5955-G

MOTION FILED
DEC 17 1987

No. 87-994

IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

GENERAL MOTORS CORPORATION and
AMERICAN NATIONAL RED CROSS,
Petitioners,

v.

WILLIAM M. BENNETT, CONWAY H. COLLIS,
ERNEST J. DRONENBERG, JR., RICHARD NEVINS,
GRAY DAVIS, and BRUCE BUNNER,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

MOTION OF THE NATIONAL RAILWAY LABOR CONFERENCE FOR LEAVE TO FILE BRIEF AS *AMICUS CURIAE* AND BRIEF AS *AMICUS CURIAE* IN SUPPORT OF THE PETITION

BENJAMIN W. BOLEY
(Counsel of Record)
CYNTHIA W. SIMON
SHEA & GARDNER
1800 Massachusetts Avenue, N.W.
Washington, D.C. 20036
(202) 828-2000

DAVID P. LEE
General Counsel
NATIONAL RAILWAY LABOR CONFERENCE
1901 L Street, N.W.
Washington, D.C. 20036
(202) 862-7218

Counsel for *Amicus Curiae*

Dated: December 17, 1987

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

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MOTION OF THE NATIONAL RAILWAY LABOR CONFERENCE FOR LEAVE TO FILE BRIEF AS *AMICUS CURIAE* IN SUPPORT OF THE PETITION

The National Railway Labor Conference ("NRLC") hereby moves, pursuant to Rule 42 of the Rules of this Court, for leave to file the attached brief as *amicus curiae*, in support of the petition for a writ of certiorari.*

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* Pursuant to Rule 36.1 of this Court, the NRLC has requested the parties' consent to the filing of the attached brief as *amicus curiae*. A letter indicating that the petitioners have consented has been filed with the Clerk of this Court. The respondents, however, declined to consent to the filing of this brief, thus necessitating this motion.

The NRLC represents nearly all of the nation's Class I railroads in a wide variety of labor relations matters of concern to the railroad industry generally. A committee established within the NRLC, the National Carriers' Conference Committee, normally represents these railroads in national collective bargaining with the unions that represent the railroads' employees. Pursuant to this collective bargaining, several national, industry-wide, employee welfare benefit plans covered by the Employee Retirement Insurance Security Act ("ERISA") have been established and are now maintained under excess-risk arrangements similar in many ways to those involved in this case. Under the railroad plans, benefits are paid on a self-insured basis, up to yearly trigger-point amounts, with funds contributed by the railroads to the plans themselves through deposits into trusts established by the railroads. Insurance companies administer the self-insured benefit payments made by the plans and, as excess-risk insurers, pay any benefits that exceed the trigger-point amounts in any given year. The railroads and the plans pay premiums to the insurance companies for this excess-risk coverage.

With the approval of the Ninth Circuit in the case for which review is sought, the California State Board of Equalization now taxes as "gross premiums" the benefits paid by petitioners' plans on a self-insured basis. The Board will almost certainly take the same position with regard to the railroad plans. The insurance companies that administer and provide excess-risk insurance to the railroad plans are directly subject to the tax. Pursuant to agreements entered into with those companies, however, the tax must be reimbursed to the insurers by the plans or the participating railroads. Accordingly, the cost of the tax would be borne not by the insurance companies but by the railroads represented by the NRLC or by the ERISA-covered plans established and maintained under collective bargaining agreements negotiated by the NRLC's National Carriers' Conference

Committee. Since the railroads bear the full cost of maintaining the plans, they would ultimately bear the full cost of the tax. The amount of that cost would be substantial. Furthermore, since the railroads' plans are nationwide, the burden might be enormous should premium taxes in place elsewhere be interpreted and applied as they have been in California, or if new taxes are created, in light of the Ninth Circuit's decision.

The NRLC and its members thus have a strong interest in ensuring that ERISA's preemption provisions are not misinterpreted. For this reason, and because the NRLC believes its accompanying brief may assist this Court in considering whether to grant the writ of certiorari sought by petitioners, the NRLC seeks leave to file the accompanying brief as *amicus curiae* in support of the petition.

Respectfully submitted,

BENJAMIN W. BOLEY
(Counsel of Record)
CYNTHIA W. SIMON
SHEA & GARDNER
1800 Massachusetts Avenue, N.W.
Washington, D.C. 20036
(202) 828-2000

DAVID P. LEE
General Counsel
NATIONAL RAILWAY LABOR CONFERENCE
1901 L Street, N.W.
Washington, D.C. 20036
(202) 862-7218
Counsel for *Amicus Curiae*

Dated: December 17, 1987

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

No. 87-994

GENERAL MOTORS CORPORATION and
AMERICAN NATIONAL RED CROSS,
Petitioners,

v.

WILLIAM M. BENNETT, CONWAY H. COLLIS,
ERNEST J. DRONENBERG, JR., RICHARD NEVINS,
GRAY DAVIS, and BRUCE BUNNER,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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BRIEF OF THE NATIONAL RAILWAY LABOR CONFERENCE AS *AMICUS CURIAE*

INTEREST OF *AMICUS CURIAE*

The interest of the *amicus* is set forth in the accompanying motion for leave to file this brief.

ARGUMENT

This case presents the important question of whether ERISA preempts a state tax on benefits paid out by employee welfare benefit plans. California imposes the tax by (1) considering the labor of employees participating in the plan to be "premiums" in the amount of plan benefits paid to them; (2) considering the plan, for pur-

poses of "receiving" the "premiums" represented by the benefits, to be an agent of the insurance company that administers and provides excess-risk insurance to the plan; and (3) taxing the insurance company on the "premiums" so "received."

Various reasons for granting the writ of certiorari are set forth in the petition. In this brief, we focus only on those reasons that pertain to ERISA's deemer clause, ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B). We urge that the writ be granted because (1) the deemer clause is the only one of the three parts of ERISA's critical and incessantly invoked preemption provision that has not yet been scrutinized by this Court and (2) what little the Court has said about the deemer clause is in serious need of clarification: in the decision below the Ninth Circuit mistakenly took the Court to have indicated in *Metropolitan Life Insurance Co.* v. *Massachusetts*, 471 U.S. 724 (1985) (hereinafter "*Metropolitan*"), that whenever a state law affecting ERISA-covered plans is imposed directly on an insurance company, the deemer clause, *for that reason alone*, is inapplicable.

ERISA's preemption provision is divided into three principal parts. First is a general preemption clause extraordinary in its breadth. ERISA § 514(a), 29 U.S.C. § 1144(a). Section 514(a) preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in [ERISA]." The Ninth Circuit held that the California premium tax as applied to petitioners' plans "relate[s]" to them and, presumably, would be preempted if § 514(a) stood alone. This Court has considered § 514(a) at length in a number of cases. *E.g.*, *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981); *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *Metropolitan*, *supra*; *Fort Halifax Packing Co.* v. *Coyne*, 107 S.Ct. 2211 (1987).

Second is the "saving clause." Section 514(b)(2)(A) provides that, except as provided in subparagraph (b),

nothing in ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." The Ninth Circuit held that the California premium tax as applied to petitioners' plans is a law that is "intimately associated with the business of insurance" and hence regulates insurance and is "saved" from preemption. This Court has twice recently addressed the "saving clause" insofar as it deals with state laws that arguably "regulate insurance." *Metropolitan*, 471 U.S. at 739-47 (laws regulating content of insurance policies fall within "saving clause"); *Pilot Life Ins. Co.* v. *Dedeaux*, 107 S.Ct. 1549, 1553-1555 (1987) (common law contract and tort remedies are not preserved by the "saving clause").

Third is the "deemer clause." Section 514(b)(2)(B) provides that no employee benefit plan covered by ERISA "shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." The Ninth Circuit held that California had *not* deemed petitioners' plans to be insurance companies or other insurers, or to be engaged in the business of insurance, for purposes of applying the state's premium tax to the benefits paid by the plans.

This Court, which in *Metropolitan* implicitly held that the "deemer clause" did not come into play where state laws mandating that certain benefits be provided in insurance policies were applied to policies sold to ERISA-covered plans, has yet to address the meaning of the "deemer clause" in any significant detail. It should do so in this case. The question of the applicability of the clause is crucial to the decision below, and the Ninth Circuit's erroneous interpretation of the clause is clearly articulated.

The state law challenged by petitioners is the application to their plans of the decision by the Supreme Court of California in *Metropolitan Life Insurance Co.* v. *State Board of Equalization*, 652 P.2d 426, 32 Cal.3d 649, 186 Cal. Rptr. 578 (1982). The California court held that, for purposes of the state's premium tax statute, "gross premiums received by" (and taxable to) an insurance company included amounts equal to the benefits paid by employers under certain kinds of plans that the insurance company administered and with respect to which it provided excess-risk insurance. In reaching this decision, the California court focused directly upon, and categorized as an insurance business, the operation of those plans. First, the court determined that plan benefits were acquired by employees in consideration of their labor; accordingly, the labor was "premium" in the amount of the benefits actually paid. 652 P.2d at 433, 32 Cal.3d at 661-62, 186 Cal. Rptr. at 585. Second, the court concluded that this premium, *i.e.*, the employees' labor in the amount of benefits paid, had been "received by" the insurance company because, among other things, the funding and payment of plan benefits by the employers were "activities [that] fall within the ambit of 'administration' of a group insurance policy and constitute doing [an insurance] business in California. Thus, the employers are to be treated as agents of [the insurance company], as a matter of law." 652 P.2d at 431, 32 Cal.3d at 659, 186 Cal. Rptr. at 583. In short, in order to equate plan benefits paid by employers with gross premiums received by the insurer, the California court of necessity deemed the employers' plans to be part of the insurer's operations. This is exactly what the plain language of ERISA's deemer clause forbids.

The Ninth Circuit nonetheless did not reach the question of the meaning of the plain language of the deemer clause. Rather, it felt constrained by this Court's decision in *Metropolitan* to conclude that if, as it found, the

California tax fell directly on insurance companies, no further exploration of the deemer clause was called for:

> "The tax at issue does not run afoul of the deemer clause. It is imposed on insurance companies, not benefit plans. It may affect benefit plans, but effects are not determinative. *Metropolitan* so holds. *Metropolitan* left intact a mandated-benefit law that had significant effects on Massachusetts plans. In so doing, it indicated that state laws affecting benefit plans may escape preemption if they fall directly on insurance companies, as the tax at issue does." 815 F.2d 1305, 1311 (9th Cir. 1987).

Metropolitan involved a Massachusetts law requiring all group health policies covering Massachusetts residents to include prescribed mental health benefits. The question was whether that requirement could be applied to policies purchased by ERISA-covered plans. This Court held that the saving clause of ERISA's preemption provision allowed the state to regulate the content of policies sold to plans despite the indirect effect the regulation would have on those plans. The Court necessarily but implicitly concluded, since the state law was upheld, that the deemer clause did not apply. See *Metropolitan*, 471 U.S. at 747. The Court did not, however, parse the clause or otherwise analyze its meaning; there was no need to do so because no contention was made that Massachusetts, in regulating insurance policies sold to plans, was in any way treating the plans as insurers or as engaging in the insurance business. Even so, the Court's opinion arguably implied a general principle: a state law that directly regulates insurance policies (or insurance companies) does not deem plans to be insurers or in the business of insurance for purposes of § 514(b)(2)(B), provided that the effect of the law upon the plans is indirect:

> "We are aware that our decision results in a distinction between insured and uninsured plans, leaving

> the former open to *indirect* regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter." (Footnote omitted; emphasis added.) *Id.* at 741.

The Court also noted that the deemer clause would forbid any *direct* regulation of plans. In support of its holding that the saving clause preserved regulation of the contents of insurance policies as well as regulation of the activities of insurance companies, the Court cited the reference to insurance contracts in the deemer clause and indicated that the clause protected plans from *direct* regulation under state insurance laws:

> "By exempting from the saving clause laws regulating insurance contracts that *apply* directly to benefit plans, the deemer clause makes explicit Congress' intention to include laws that regulate insurance contracts within the scope of the insurance laws preserved by the saving clause. Unless Congress intended to include laws regulating insurance contracts within the scope of the insurance saving clause, it would have been unnecessary for the deemer clause explicitly to exempt such laws from the saving clause when they are applied *directly* to benefit plans." (Emphasis added.) *Id.* at 741.

And earlier in its opinion the Court mentioned with apparent approval the state's decision, in light of the deemer clause, not to enforce the mandated benefit law "against benefit plans *directly*." *Id.* at 735-36 n.14. (Emphasis added.)

The Ninth Circuit apparently took the deemer clause references in *Metropolitan* to mean that, since the California tax (like the Massachusetts law) was imposed directly on insurance companies, the deemer clause did not apply and further inquiry was unnecessary. As a result, the Ninth Circuit failed to consider that, under

the plain meaning of the deemer clause, California (unlike Massachusetts) had deemed plan benefits to be insurance premiums, employers to be insurance agents, and plans to be in the business of insurance, all in order to apply to plan benefits the state's tax on "gross premiums received" by insurance companies. The Ninth Circuit's interpretation of what *Metropolitan* means insofar as the application of the deemer clause is concerned goes far toward reading that clause out of the statute.[1] It also ignores the basic canon of statutory construction that one "must begin with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose." *Park 'N Fly, Inc. v. Dollar Park and Fly, Inc.*, 469 U.S. 189, 194 (1985). Accord, *Metropolitan*, 471 U.S. at 740; *Shaw*, 463 U.S. at 97.

CONCLUSION

We doubt that the Court intended its references to the deemer clause in *Metropolitan* to father the result reached by the Ninth Circuit. The Court should thus grant the writ of certiorari in this case to clarify what it said in *Metropolitan* and because of the significance of the deemer clause in the burgeoning body of ERISA

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[1] The vitality of the deemer clause has been further jeopardized by a recent Sixth Circuit decision. *Northern Group Services, Inc.* v. *Auto Owners Insurance Co.*, to be printed at 833 F.2d 85 (6th Cir. 1987) (available on WESTLAW). The Sixth Circuit held that even where a state law regulating insurance directly affects (indeed prohibits) the very terms of ERISA-covered plans, the deemer clause may nonetheless be inapplicable if the interests of "state primacy in the regulation of insurance" outweigh the "federal interest in national uniformity" evidenced by ERISA. *Id.*, WESTLAW printout at 12. The court upheld, against an ERISA preemption challenge, a Michigan law providing that in certain circumstances coverage under no-fault automobile insurance is "secondary" when "other coverage" is available and that such "other coverage" is primary. "Other coverage" included coverage provided by any plan subject to ERISA, even if the plan itself specified that its coverage was secondary.

preemption litigation. See *SEC* v. *United Benefit Life Insurance Co.*, 387 U.S. 202, 207 (1967) (certiorari granted because of "the importance of the issue, and the need for clarifying the implications of" a prior decision of this Court).

Respectfully submitted,

BENJAMIN W. BOLEY
(Counsel of Record)
CYNTHIA W. SIMON
SHEA & GARDNER
1800 Massachusetts Avenue, N.W.
Washington, D.C. 20036
(202) 828-2000

DAVID P. LEE
General Counsel
NATIONAL RAILWAY LABOR CONFERENCE
1901 L Street, N.W.
Washington, D.C. 20036
(202) 862-7218

Counsel for *Amicus Curiae*

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BRIEF AMICI CURIAE FOR AMERICAN COUNCIL OF LIFE INSURANCE AND HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF THE PETITION

Of Counsel:
JACK H. BLAINE
Vice President, State Relations, and General Counsel
PHILLIP E. STANO
Senior Counsel
AMERICAN COUNCIL OF LIFE INSURANCE
1001 Pennsylvania Avenue, N.W.
Washington, D.C. 20004-2599
(202) 624-2183

JOE W. PEEL
Vice President and General Counsel
JANA LEE PRUITT
Assistant Counsel
HEALTH INSURANCE ASSOCIATION OF AMERICA
1025 Connecticut Avenue, N.W.
Suite 1200
Washington, D.C. 20036-3998
(202) 223-7780

ERWIN N. GRISWOLD
Counsel of Record
PATRICIA A. DUNN
JONES, DAY, REAVIS & POGUE
Metropolitan Square
1450 G Street, N.W.
Washington, D.C. 20005-5701
(202) 879-3939
Counsel for the Amici

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

QUESTIONS PRESENTED

1. Whether a state tax that "relates to" an employee benefit plan under § 514(a) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1144 (a), by explicitly including the plan's benefit payments in the amounts subject to tax is saved from preemption as a law which "regulates insurance" under ERISA § 514 (b) (2) (A) because the legal incidence of the tax is on insurance companies?

2. Whether such a state tax deems ERISA plans "to be engaged in the business of insurance" in violation of § 514(b) (2) (B) of ERISA, 29 U.S.C. § 1144(b) (2) (B), because it treats the benefits paid by such plans as a taxable cost of "insurance", regardless of the extent of insurance actually purchased by the plans?

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BRIEF AMICI CURIAE FOR AMERICAN COUNCIL OF LIFE INSURANCE AND HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF THE PETITION

This brief is filed on behalf of the American Council of Life Insurance ("Council") and the Health Insurance Association of America ("HIAA"), as amici curiae, in support of the petition for certiorari.[1]

INTERESTS OF THE AMICI

The Council is the largest life insurance trade association in the United States, representing the interests of

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[1] Consent from counsel for both parties has been filed with the Clerk of this Court.

645 member life insurance companies. The Council's members, which include most of the country's major life insurers, currently hold ninety-five percent of the life insurance in force in legal reserve life insurance companies in the United States. The HIAA represents the interests of 345 member companies, which provide approximately ninety percent of the health insurance written by commercial insurance companies in the United States. The combined memberships of the HIAA and the Council represent over ninety percent of such health insurance.

The insurance industry plays a critical role in providing welfare benefits to members of the nation's workforce through benefit plans governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.* As of 1979, insurance companies —including many members of the Council and the HIAA —funded through group policies approximately 99 percent of the benefit plans in the United States which covered fewer than 100 participants. *See* "Employee Welfare Benefit Plans and Plan Sponsors in the Private Nonfarm Sector in the United States, 1978-79," Health and Population Study Center, Battelle Human Affairs Research Centers, Vol. IV (1980), at 43-45. Approximately 92 percent of the plans in this country covering greater than 100 participants were also funded in this way. *Id.* In many instances, insurers assume administrative responsibilities for insured, partially-insured and self-insured plans. *Id.* Thus, members of the Council and the HIAA make welfare benefit plans possible for countless employers—large and small—thereby ensuring that the great mass of workers in this country receive some form of life and health insurance protection.

The legal and practical consequences of the Ninth Circuit's opinion below are matters of grave concern to the members of the Council and the HIAA. That decision—that ERISA does not preempt a state premium tax assessed indirectly against the self-funded benefits of an

employee benefit plan simply because the plan purchases excess-risk insurance—greatly limits the funding choices available to employers who voluntarily establish those plans and penalizes ERISA plans partially funded by employers. If the decision below stands, employers who bear all of the risk of paying the uninsured benefits of such plans will be subjected to the cost resulting from the tax on those benefits merely because they purchase excess-risk insurance.

STATUTES INVOLVED

1. Section 514(a) of ERISA provides, in pertinent part, that:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003 (a) of this title and not exempt under section 1003 (b) of this title.

29 U.S.C. § 1144(a).

2. Section 514(b) of ERISA provides, in pertinent part, that:

> (2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.
>
> [(2)](B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies, [or] insurance contracts. . . .
>
> * * * *

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51).

[(5)](B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section—

(i) any State tax law relating to employee benefit plans . . . .

29 U.S.C. § 1144(b).

3. Section 514(c) of ERISA provides, in pertinent part, that:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. . . .

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

29 U.S.C. § 1144(c).

4. The McCarran-Ferguson Act provides, in relevant part, that:

[1011.] Congress declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

[1012.] (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business

> of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance. . . .

15 U.S.C. §§ 1011-1012.

STATEMENT

General Motors Corporation ("GMC") and the American National Red Cross ("Red Cross") sponsor ERISA-covered plans which provide disability and health care benefits to employees. They fund the plans with company assets and "excess-risk" policies purchased from Metropolitan Life Insurance Company ("Metropolitan"). Under this funding arrangement, GMC and Red Cross bear the risk of paying, out of their own funds, all claims up to a specified level, i.e., the so-called "trigger point". Metropolitan pays all claims above the trigger point.

The State of California taxes "gross premiums . . . received" by insurance companies that do business in the State. Cal. Rev. & Tax Code § 12221 (West 1970 & 1987 Supp.). "Gross premiums" include, as a matter of judicial construction, "the entire cost of an employee benefit plan." *Metropolitan Life Insurance Co. v. State Board of Equalization*, 32 Cal. 3d 649, 186 Cal. Rptr. 578, 585 (1982). Thus, in calculating the tax imposed on excess-risk insurers, California includes not only the actual premiums received by insurers for their excess-risk policies, but also the amount of benefits paid by employers, from company assets, to plan beneficiaries. *Id.* at 584-85.[2] Consistent with state law, therefore, the California Board of Equalization and its members (the "Board") assessed a premium tax on Metropolitan, based on the premiums paid to it by GMC and Red Cross plus the actual bene-

[2] This construction is premised on the California Supreme Court's conclusions that employers who sponsor employee benefit plans are "mere agents" of insurers, and that the benefits that these agents pay to employees under such plans are in essence "premiums" paid to the insurer to satisfy employee claims.

fits paid to beneficiaries under the plans. Pursuant to the terms of their excess-risk policies, GMC and Red Cross, in turn, reimbursed Metropolitan for the total premium tax assessed.

THE PROCEEDINGS BELOW

GMC and Red Cross filed suit in the United States District Court for the Central District of California, claiming, *inter alia*, that California's taxation practice is preempted by ERISA. The district court agreed. Rejecting the Board's argument that the premium tax merely taxed the business of insurance, the court concluded that calculating "gross premiums" by reference to benefits paid under the plans represents an indirect tax on the benefits themselves. Thus, it concluded that "this taxation practice is preempted because it 'relates to' . . . the plans by using the plans' payments as a means for measuring taxable premiums." Appendix at 23a, *General Motors Corp. v. California Board of Equalization*, 600 F. Supp. 76, 80 (C.D. Cal. 1984), *amended*, 626 F. Supp. 439 (C.D. Cal. 1985).

The Ninth Circuit reversed. At the outset, the court agreed that the tax " 'relate[s] to' benefit plans . . . [because it] is computed on the basis of benefits paid by the plans." Appendix at 11a, *General Motors Corp. v. California Board of Equalization*, 815 F.2d 1305, 1309 (9th Cir. 1987). But, relying on this Court's decision in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985) ("*Metropolitan Life*"), and the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1012, it concluded that ERISA's insurance saving clause—which exempts from preemption state laws that "regulat[e] insurance", ERISA § 514(b), 29 U.S.C. § 1144(b)—preserves the states' ability to tax insurance as well. Appendix at 13a, 815 F.2d at 1810. Finding that California's premium tax "is intimately associated with the business of insurance" and that the "incidence of the tax remains on the insurer, not the plans," the court held it to be saved

from ERISA's preemptive reach. *Id.* Turning to the "final step" in the preemption analysis, it then concluded that the tax "does not run afoul of the deemer clause [29 U.S.C. § 1144(b)(2)(B)] . . . [because] [i]t is imposed on insurance companies, not benefit plans." Appendix at 14a, 815 F.2d at 1311. Thus, the court concluded that ERISA did not preempt California's premium tax.

REASONS FOR GRANTING THE WRIT

1. The Court Below Decided An Important Issue Of Federal Law In A Manner Inconsistent With The Decisions Of This Court

ERISA's "deliberately expansive", *Pilot Life Insurance Co. v. Dedeaux*, 107 S.Ct. 1549, 1552 (1987), but elusively crafted, preemption clause once again raises an important issue for review by the Court: whether a state premium tax, which is nominally assessed against insurers but is calculated in part based on the level of benefits paid under the self-funded portion of an ERISA plan, escapes preemption as a law which "regulates insurance" within the meaning of ERISA's saving clause. The court below held that it does. In doing so, it "[e]levat[ed] the incidence of the tax [on the insurer] over [its] effects [on ERISA plans]"—reading *Metropolitan Life* to require such a result. Appendix at 14a, *General Motors Corp. v. California Board of Equalization*, 815 F.2d at 1310. This is a misapplication of ERISA, which should be reviewed by this Court.

ERISA's "virtually unique pre-emption provision," *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1, 24 n.26 (1983), "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . ." 29 U.S.C. § 1144(a). Giving "[t]he phrase 'relate to' . . . its broad common-sense meaning," this Court has stated "that a state law 'relate[s] to' a benefit plan 'in the normal sense of the phrase, if it has a connection with or reference to

such a plan.'" *Metropolitan Life*, 471 U.S. at 739, *quoting Shaw v. Delta Air Lines*, 463 U.S. 85, 97 (1983). Thus, "[ERISA's] pre-emption clause is not limited to 'state laws specifically designed to affect employee benefit plans,'" *Pilot Life Insurance Co. v. Dedeaux*, 107 S. Ct. at 1553, *quoting Shaw v. Delta Air Lines*, 463 U.S. at 98, because "even indirect state action . . . may encroach upon the area of exclusive federal concern." *Alesssi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981); *see also Metropolitan Life*, 471 U.S. at 739.

California—with the endorsement of the court below—has indirectly, but seriously, encroached upon ERISA's exclusive domain. Plainly, if California had taxed directly a wholly self-insured employee benefit plan, in amounts that increased concurrently with the level of benefits it paid to beneficiaries, there would be no doubt that ERISA would preempt the State's action. *See, e.g., National Carriers' Conference Committee v. Heffernan*, 454 F. Supp. 914 (D. Conn. 1978) (state statute requiring plans to pay an annual tax based on the amounts of benefits paid held preempted by ERISA). Such a tax—no differently than the premium tax at issue here—would surely "relate to" an employee benefit plan.[3] The mere

[3] The clear words of ERISA and its legislative history permit no other result. Indeed, though specifically presented with a recommendation to exclude from preemption the states' authority to tax pension plans in 1974, Congress did not do so. *See* Administration Recommendations to the House and Senate Conferees on H.R. 2 to Provide for Pension Reform (April 1974), *reprinted in* 3 Legislative History of the Employee Retirement Income Security Act of 1974 ("Legislative History"), at 5050, 5145-47. Moreover, eight years later, when it created a narrow exception to ERISA's preemption clause for Hawaii's health care statute, Congress reaffirmed that ERISA preempts state tax laws. *See* 29 U.S.C. § 1144(b)(5)(B)(i) (Hawaii exemption "shall [not] be construed to exempt from [§ 514(a)] any State tax law relating to employee benefit plans"); *see also* 128 Cong. Rec. S13151 (daily ed. Oct. 1, 1982) (Senator Dole) ("Hawaii law . . . would not be preempted by ERISA to the extent that [it] does not relate to matters

fact that the "incidence" of California's premium tax rests on the plan's excess-risk insurer, rather than the plan itself, should not protect it from preemption as a law which "regulates insurance", particularly where the insurer bears no risk of paying, and receives no premiums for, the benefits subject to taxation. That such taxation is, in substance, a tax on an ERISA plan—and not, as its form might suggest, a tax on insurance—is starkly evident where, as here, the plan sponsors fund the taxed benefits with company assets, purchase insurance only to cover excess plan liabilities, and bear the entire risk of paying the uninsured benefits subject to the tax.

The contrary conclusion of the court below rests on its misinterpretation of *Metropolitan Life*. Nothing in *Metropolitan Life*, however, compels the court's elevation of form over substance. The Court in *Metropolitan Life* narrowly held that a state statute regulating the content of insurance policies was saved from preemption by ERISA as a law that "regulates insurance". But the Court did not hold, as the court below found, that "effects are not determinative" in ERISA preemption analysis. Appendix at 14a, 815 F.2d at 1311. Nor did it implicitly hold that ERISA's saving clause protects indirect state taxation of ERISA plans that self-insure all but excess plan liabilities. Review is thus necessary to correct the

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thoroughly regulated under ERISA or impose tax liability on insurance premiums or benefits"); 128 Cong. Rec. H9609 (daily ed. Dec. 13, 1982) (Representative Erlenborn) ("amendments . . . serve to reaffirm the broad Federal preemption of State laws as they relate to employee benefit plans as was the original intent of ERISA"). Congress did so again when, in 1984, it carved out an exception to § 514 for qualified state domestic relations orders. *See, e.g.*, H.R. Rep. No. 655, 98th Cong., 2d Sess., pt. 1, at 42 (1984) ("the original broad intent behind ERISA's rule of preemption . . . has always been to preempt state or local government laws or actions of any type which directly or indirectly relate to any employee benefit plan subject to ERISA. . . . [T]he Committee reasserts that a state tax levy on employee welfare benefit plans is preempted by ERISA").

Ninth Circuit's misapplication of *Metropolitan Life* and to "preclude [California] from avoiding through form the substance of [ERISA's] preemption provision." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. at 525.

2. The Decision Below Has A Far-Reaching And Impermissible Impact On Plan Funding Decisions

California's indirect taxation practice encroaches on ERISA's exclusive domain in yet another way: it undercuts employer discretion to fund employee welfare benefit plans "through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1). Because the decision below effectively eliminates one method of plan funding—a combination of company assets and excess-risk insurance—and disrupts the uniform administration of benefit plans that ERISA was designed to foster, this Court should review it.

The decision below—that ERISA does not preempt a state premium tax assessed indirectly against the self-funded benefits of an ERISA plan simply because the plan purchases excess-risk insurance—greatly limits the funding choices available to employers who voluntarily establish ERISA plans. The practical effect of the decision below is to inflate, perhaps prohibitively, the cost of excess-risk insurance to plan sponsors and thus to discourage their reliance on innovative funding methods. By discouraging excess-risk insurance, the decision would leave plans vulnerable to catastrophic losses that may deplete plan assets substantially, if not entirely. California's practice thus penalizes creative compromises that might lower costs for both employers and insurers and might encourage the growth of benefit plans.

Such results are entirely at odds with the words and intent of ERISA. Because the decision below effectively eliminates a method of funding that ERISA permits, it intrudes on ERISA's exclusive domain. *Cf. Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. at 524 (New Jersey statute which prohibits offsetting pension ben-

efits with workers' compensation benefits held preempted by ERISA "because it eliminates one method for calculating pension benefits—integration—that is permitted by federal law" and that ERISA left subject to the discretion of pension plan sponsors). Indeed, if states, like California, are permitted to interfere with employer discretion by encouraging or discouraging certain funding methods, employers who operate—and insurers who provide insurance for—multi-state plans will be forced to conform to a patchwork of state-preferred funding methods or eliminate their plans altogether. But, as this Court stated in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 105 and n.25, and recently reiterated in *Fort Halifax Packing Co. v. Coyne*, 107 S. Ct. 2211 (1987), subjecting employers with nationwide plans to the varied, and perhaps inconsistent, requirements of different states' laws:

> would produce considerable inefficiencies, which the employer might choose to offset by lowering benefit levels. . . . 'ERISA's comprehensive preemption of state law was meant to minimize this sort of interference with the administration of employee benefit plans,' . . . so that employers would not have to 'administer their plans differently in each State in which they have employees.'

Id. at 2217 (citation omitted). *Cf. Minnesota Chamber of Commerce and Industry v. Hatch*, No. Civil 4-87-707 (D. Minn. Oct. 29, 1987) ("If such ownership of [stop-loss] insurance were enough to prevent ERISA preemption, plan providers would be subject to a myriad of state regulation which would operate to frustrate ERISA's uniform treatment of benefit plans.").[4]

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[4] Any other conclusion would disregard Congress' explicit intent to provide for uniformity in the administration of ERISA plans:

> Except . . . in certain . . . enumerated circumstances, state law is preempted. Because of the interstate character of employee benefit plans, *the Committee believes it essential to provide for a uniform source of law in the areas of vesting, funding, insurance and portability standards*, for evaluating fiduciary con-

The impact of the decision below on employee benefit plan administration is thus potentially far-reaching. The disincentives spawned by California's taxing scheme seriously threaten the stability of multi-state employee benefit plans which rely in part on insurance funding or the administrative services of insurers.[5] It threatens reversal of a trend away from fully-insured plans to self-funded plans which rely on insurers only for excess liability coverage or administrative services. Indeed, while less than five percent of total insurance company group coverage in 1975 consisted of such innovative funding arrangements, like that at issue here, those arrangements represented an estimated 30 percent of the total insurance group coverage in 1981. *See* HIAA, Source Book of Health Insurance Data, 1982-1983, at 8. Moreover, that

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duct, and for creating a single reporting and disclosure system in lieu of burdensome multiple reports.

S. Rep. No. 127, 93d Cong., 1st Sess. 35 (1973), *reprinted in* 1 Legislative History, at 621 (emphasis added); *see also* 120 Cong. Rec. 29,197 (1974) (Representative Dent) (broad federal preemption was designed to eliminate "the threat of conflicting and inconsistent State and local regulations"); 120 Cong. Rec. 29,933 (Senator Williams) ("the substantive and enforcement provisions . . . are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans"); 120 Cong. Rec. 29,942 (1974) (Senator Javits) ("the emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required—but for certain exceptions—the displacement of State action in the field of private employee benefit programs").

[5] Because California taxes "the entire cost of an employee benefit plan," *Metropolitan Life Insurance Co. v. State Board of Equalization*, 32 Cal. 3d 649, 186 Cal. Rptr. 578, 585 (1982), even plans that purchase only the administrative services of an insurance company may be subject to the tax. Moreover, the effect of the decision below is only amplified by the fact that California's taxing practice is not unique. Indeed, Texas has recently enacted, and Michigan considered adopting, a similar practice. *See* 1987 Tex. Gen. Laws, 70th Leg., 2d C.S., Ch. 5, Art. 8, p. 57. That more states may follow suit in the wake of the decision below, is hardly unexpected.

trend has continued. A recent study reveals that over 80 percent of employees receiving employer-provided health care benefits in 1980 were covered by commercial insurance carrier and Blue Cross-Blue Shield policies. *See* United States Department of Labor, Bureau of Labor Statistics, "Employee Benefits in Medium and Large Firms," 1986 (June 1987), at 32 and Table 47. Such policies accounted for only one-half or less of health care coverage in 1986. *Id.*

Review of the decision below is thus vitally important. To deny review, and thereby leave intact state taxing practices like California's, would only create disuniformities in plan administration and discourage innovative funding methods—and thus the provision of welfare benefits to the nation's workers—in clear derogation of ERISA.

3. The Decision Below Presents An Opportunity To Clarify The Respective Roles Of ERISA's Saving And Deemer Clauses

Review is necessary for still another reason: the court below gave ERISA's saving clause an unduly broad reading, and construed the deemer clause too narrowly, when it held that a state premium tax calculated with reference to the level of benefits paid under the self-funded portion of an ERISA plan is not preempted by ERISA. The decision below neither comports with a "commonsense" interpretation of ERISA's insurance saving clause, read in light of *Metropolitan Life* and the McCarran-Ferguson Act, nor gives due consideration to ERISA's proscription against "deeming" plans to be engaged in the "business of insurance."

ERISA saves from preemption "any law of any State which *regulates insurance*." 29 U.S.C. § 1144(b)(2)(A) (emphasis added). "[T]he language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose," *Metropolitan Life*, 471 U.S. at 740, *quoting Park'n Fly, Inc. v. Dollar Park and Fly, Inc.*, 469 U.S. 189, 194 (1985), strongly suggest that ERISA saves from preemption only state regulation of insurance, and not, as the court below found, state taxation of the self-insured benefits of an ERISA plan.[6] That such state tax laws do not constitute insurance regulation draws support from *Metropolitan Life*. In that case, the Court—as it has in interpreting other words in ERISA—gave the phrase "regulates insurance" its practical and "commonsense" meaning. *Metropolitan Life*, 471 U.S. at 740. It

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[6] The McCarran-Ferguson Act, which provides in part that "[t]he business of insurance . . . shall be subject to the laws of the several States which relate to the *regulation or taxation* of such business," 15 U.S.C. § 1012(a) (emphasis added), was obviously in mind when Congress saved from ERISA preemption state laws that "regulat[e] insurance." *See Metropolitan Life*, 471 U.S. at 744 n.21. The omission from the saving clause of any reference to state laws which "tax" insurance is conspicuous when the language of the two clauses is carefully considered. Congress surely meant something different by the terms "regulation" and "taxation", as the words of the McCarran-Ferguson Act and its legislative history amply reflect. *See* H.R. Rep. No. 143, 79th Cong., 1st Sess. 2 (1945) (bill designed to address questions as to the "validity of State tax laws as well as State regulatory provisions"); 91 Cong. Rec. 480-81, 483 (Jan. 25, 1945) (Senators Ferguson and Radcliffe); *id.* at 485-86 (Senator Revercomb); *id.* at 487 (Senator Ellender). Whether Congress intended, when it omitted "taxation" from the saving clause, to leave ERISA's expansive preemption clause effective as to state taxation of the self-insured portion of a partially-insured ERISA plan warrants consideration by this Court.

thus concluded that Massachusetts' mandated-benefits law was saved from preemption as a law which "regulates insurance," noting that regulation of the content of insurance contracts—no differently than "regulation of the carrier [and] regulation of the sale and advertising of the insurance", *id.* at 728—is precisely the type of state insurance regulation that the McCarran-Ferguson Act preserves.[7]

Regulation of the substantive terms of insurance contracts, however, is distinctly different from the tax practice at issue here. Unlike the mandated-benefits law at issue in *Metropolitan Life*, the California tax involved here does not "regulate" the content of insurance contracts in California. Nor, given its substantive impact on ERISA plans, can the tax reasonably be found to "regulate" insurers and their transacting of insurance business within the State. To hold otherwise, and apply California's taxing practice to the self-funded portion of an employee benefit plan, would attribute to the phrase "regulates insurance" an overly broad meaning which makes little common sense.

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[7] Indeed, the Court in *Metropolitan Life* articulated its interpretation of "regulation" with clarity. To illustrate the types of state insurance regulation preserved by the McCarran-Ferguson Act, it explained (*id.* at 728 n.2) (citation omitted and emphasis added):

> Laws *regulating* the insurer include, for example, those governing solvency or the qualification of management. Laws *regulating* aspects of transacting the business of group insurance include, for example, those regulating claims practices or rates. Finally, laws *regulating* the content of group policies include, in addition to the mandated-benefit statutes under consideration here, those requiring the policies to provide grace periods and conversion privileges. . . . All three varieties of *regulation* are common.

See also SEC v. National Securities, Inc., 393 U.S. 453, 460 (1969) ("Congress was concerned [in the McCarran-Ferguson Act] with the type of state regulation that centers around the contract of insurance. . .").

That California's tax practice does not "regulat[e] insurance" also draws support from this Court's decisions under the McCarran-Ferguson Act. Specifically, this Court has articulated three criteria for determining whether a particular activity constitutes the "business of insurance" within the meaning of the McCarran-Ferguson Act: "*first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry." *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119, 129 (1982). Applying these criteria to determine whether a state law "regulates insurance" within the meaning of ERISA's saving clause, as this Court did in *Metropolitan Life*, 471 U.S. at 742-44, and *Pilot Life Insurance Co. v. Dedeaux*, 107 S. Ct. at 1553-55, suggests that the tax practice at issue here is not saved from preemption. At a minimum, a state taxing practice which, though nominally an insurance law, taxes the self-insured benefits of an ERISA plan does not regulate the spreading or transferring of the policyholder's risk, which is the "one 'indispensable characteristic of insurance'." *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. at 127, *quoting Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 211-12 (1979).

Further, the court below read ERISA's "deemer" clause too restrictively when it concluded that California's indirect taxation of plan benefits did not "run afoul of the deemer clause." Appendix at 14a, 815 F.2d at 1311. That clause provides that "[no] employee benefit plan . . . shall be deemed to be an insurance company . . . or to be engaged in the business of insurance . . . for purposes of any law of any State *purporting* to regulate insurance companies. . . ." 29 U.S.C. § 1144(b)(2)(B) (emphasis added). Through its tax practice, California certainly "*purport*[*s*] to regulate insurance com-

panies." *Id.* But, in effect, it taxes the self-insured benefits of ERISA plans. Because it effectuates this taxation by treating plan sponsors as the excess-risk insurer's "agents"—though the plan itself bears *all* the risk of paying pre-trigger benefits—and by treating benefit payments to plan participants as insurance "premiums", California necessarily deems the plan to be engaged in the "business of insurance" in violation of ERISA's deemer clause.[8]

Only this Court can correct the misapplication of ERISA's saving and deemer clauses by the court below. Resolving the question whether these clauses, properly construed, protect from preemption indirect state taxation of the self-insured benefits of an ERISA plan is critically important to states, insurers and plan administrators alike. Review by this Court is required to avoid continued struggle—with numerous cases in the lower courts—over the proper interpretation of ERISA's preemption clauses and to preserve ERISA's primacy in the field of employee benefits.

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[8] The conclusion that the deemer clause precludes California's taxing practice draws support from the cases—including some within the Ninth Circuit—that have concluded that the deemer clause protects self-insured plans even if the plans purchase excess insurance. *See, e.g., United Food & Commercial Workers, et al. v. Pacyga*, 801 F.2d 1157, 1161-62 (9th Cir. 1986); *Moore v. Provident Life and Accident Insurance Co.*, 786 F.2d 922, 927 (9th Cir. 1986); *Minnesota Chamber of Commerce and Industry v. Hatch*, No. Civil 4-87-707 (D. Minn. Oct. 28, 1987). *But cf. Northern Group Services, Inc. v. Auto Owners Insurance Co.*, No. 86-1614 (6th Cir. Nov. 12, 1987) (holding self-insured plans to be subject to state "coordination of benefits" regulation, court concluded that the deemer clause overrides the saving clause only when there is "some ERISA interest in uniformity to outweigh the McCarran-Ferguson interest in state regulation of insurance").

CONCLUSION

For the reasons set forth above and for the additional reasons advanced in the Petition, the writ of certiorari should be granted.

Respectfully submitted,

Of Counsel:
JACK H. BLAINE
Vice President, State Relations, and General Counsel
PHILLIP E. STANO
Senior Counsel
AMERICAN COUNCIL OF LIFE INSURANCE
1001 Pennsylvania Avenue, N.W.
Washington, D.C. 20004-2599
(202) 624-2183

JOE W. PEEL
Vice President and General Counsel
JANA LEE PRUITT
Assistant Counsel
HEALTH INSURANCE ASSOCIATION OF AMERICA
1025 Connecticut Avenue, N.W.
Suite 1200
Washington, D.C. 20036-3998
(202) 223-7780

ERWIN N. GRISWOLD
Counsel of Record
PATRICIA A. DUNN
JONES, DAY, REAVIS & POGUE
Metropolitan Square
1450 G Street, N.W.
Washington, D.C. 20005-5701
(202) 879-3939
Counsel for the Amici

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

GENERAL MOTORS CORPORATION and
AMERICAN NATIONAL RED CROSS,
Petitioners,

v.

WILLIAM M. BENNETT, CONWAY H. COLLIS,
ERNEST J. DRONENBERG, JR., RICHARD NEVINS,
GRAY DAVIS, and BRUCE BUNNER,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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BRIEF AMICUS CURIAE OF THE CHAMBER OF COMMERCE OF THE UNITED STATES IN SUPPORT OF PETITIONERS

Of Counsel
STEPHEN A. BOKAT
NATIONAL CHAMBER
LITIGATION CENTER, INC.
1615 H Street, N.W.
Washington, D.C. 20062
(202) 463-5337

CARL L. TAYLOR *
JOHNSON & SWANSON
Columbia Square
Suite 660 West
555 Thirteenth Street, N.W.
Washington, D.C. 20004
(202) 383-8760

WILLIAM B. MCCLURE, JR.
J. GORDON CHRISTY
JOHNSON & SWANSON
900 Jackson Street
Dallas, Texas 75202-4499
(214) 977-9000

Counsel for the Chamber of Commerce of the United States, Amicus Curiae

* Counsel of Record

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

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BRIEF AMICUS CURIAE OF THE CHAMBER OF COMMERCE OF THE UNITED STATES IN SUPPORT OF PETITIONERS

STATEMENT OF INTEREST

The Chamber of Commerce of the United States ("Chamber") is the nation's largest federation of businesses, with a membership consisting of more than 180,000 corporations, partnerships, and proprietorships, as well as several thousand trade associations and state

and local chambers of commerce. Many of the Chamber's members have established employee benefit plans. A central aspect of the Chamber's functions and activities is presenting its members' views on vital issues affecting business before all branches of the federal government. In this capacity the Chamber has participated as *amicus curiae* in a number of cases involving the interpretation of statutes governing the relations of labor and the business community.

The pre-emption provision of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq.*, at issue here broadly pre-empts state regulation and taxation of employee benefit plans subject to ERISA. The State of California is indirectly taxing employee benefit plans governed by ERISA. The chamber is disturbed by both the State of California's disregard of ERISA's preemption provisions and the effects that indirect state taxation will have on employee benefit plans by: (1) reducing the level of benefits to employees; (2) discouraging the establishment, growth, or development of benefit plans; (3) encouraging other states to take similar actions encroaching upon, incrementally diminishing, and detracting from the uniform and integrated scheme of regulation created by Congress.

If the decision of the Court of Appeals for the Ninth Circuit in *General Motors Corp. v. California State Bd. of Equalization*, 815 F.2d 1305 (9th Cir. 1987) is not reversed, the Congressional policies sheltering employee benefit plans from state regulation and taxation and favoring the expansion, growth, development, and administrative efficiency of benefit plans will be undermined, and both employer and employee will suffer.

Because the Chamber is uniquely qualified to present to this Court the broad business perspective on this critical issue, it submits this brief in support of and urges the Court to grant the Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit.

STATEMENT OF THE CASE

Section 514 of the ERISA precludes states from taxing benefit plans directly. The question in this case is whether Section 514 permits them to do so indirectly under the guise of a legal fiction, whereby benefit plan payments attributable to the sponsoring employer as opposed to an insurance company are deemed to be insurance premiums taxable to a plan's excess risk insurer.

Petitioners, General Motors Corporation and the American National Red Cross are fiduciaries and sponsoring employers of certain "employee welfare benefit plans" (employee disability and health care plans) within the meaning of 29 U.S.C. § 1002. Petitioners fund the plans from a combination of company assets and "excess-risk" policies from Metropolitan Life Insurance Company. Under the benefit plans petitioners fund all benefit claims out of company assets up to a certain annual aggregate level or trigger point. Metropolitan is responsible for paying any claims above this point under the "excess risk" policies. General Motors v. California Board of Equalization, Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit, Appendix p. 6a (filed December 14, 1987) (hereinafter cited as "App.").

The Constitution of the State of California at Cal. Cons. Art. XIII, § 28(c) empowers the State of California to tax "gross premiums received" by Insurance companies doing business in the state. In *Metropolitan Life Ins. Co. v. State Board of Equalization*, 32 Cal. 3d 649, 652 P.2d 426 (1982), the California Supreme Court held that for purposes of California state law "gross premiums" received by an insurance company include not only amounts paid by an ERISA plan or sponsoring employer to an insurer for an excess risk policy, but also the aggregate amount of benefits below the trigger point paid by employers under the benefit plan directly to their

employees and dependents out of plan assets. *Metropolitan Life Ins. Co. v. State Board of Equalization*, 652 P.2d at 433. The California court reached this result by concluding that for purposes of California state law the employer, in discharging plan benefit obligations, is a "mere agent" of the insurer that provides the excess risk coverage. 652 P.2d at 430.

Relying on the California Supreme Court's holding, Respondents levied taxes upon Metropolitan based not only upon the premiums received for the excess-risk policies and administrative functions but also upon the aggregate total of benefits paid out of Petitioner's employee benefit funds.[1]

Petitioners filed suit in federal court claiming the tax upon benefits paid directly out of plan funds below the trigger point was pre-empted by Section 514 of ERISA. The District Court agreed that State's action "related to" the benefit plans and was tantamount to taxing the benefit funds:

> The defendants are indirectly taxing benefit payments and they are impeding the discretion of plan sponsors to fund their plan guarantees through a combination of general assets and risk insurance.

General Motors v. California State Board of Equalization, 600 F. Supp. 76, 80 (C.D. Calif. 1984).[2]

The Court of Appeals for the Ninth Circuit agreed that the tax "relates to" benefit plans and "is computed on the basis of benefits paid by the plans." *General Motors v. California Board of Equalization*, 815 F.2d 1305,

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[1] These tax levies were passed on to the Petitioners as Metropolitan was indemnified by them.

[2] The District Court concluded that the legislative history of ERISA indicated that Section 1144(b)(5)(B)(i) was "directed to all [state] tax laws" and pre-empted California's *indirect* taxation of employee benefit plans. 600 F. Supp. at 80.

1309 (1987). The court, however, implicitly accepted for federal purposes the California Supreme Court's fiction that benefits paid are insurance premiums and concluded that the tax was saved from pre-emption because ERISA's pre-emption "saving clause," Section 514(b)(2)(A), "must be construed to cover *taxation* of insurance . . . for the tax is *intimately associated* with the business of insurance." *Id.* at 1310 (emphasis added). The court further concluded that the tax did not run afoul of the "deemer clause," section 514(b)(2)(B),[3] because the legal "*incidence*" of the tax fell on the insurance company not the plans. *Id.* at 1310. Although the court concluded that "elevating the incidence of the tax over the *effects* may be somewhat formalistic . . . it is the method *Metropolitan* [471 U.S. 724] *requires* us to employ in cases of this sort." *Id.* (emphasis added).

REASONS TO GRANT THE WRIT

The court of appeals' decision places employee benefit plans in a stark dilemma. If a plan uses services of an insurance company or is covered by an excess risk policy, a state can always interpret its insurance laws so as to deem all plan benefits paid to be insurance premiums for state law purposes, regardless of how such payments might be classified under traditional insurance economic analysis. A state can then tax the insurance company which will then pass the cost of the tax on to the plan. Faced with such a situation plans must either (i) have no connection whatsoever with insurance companies and

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[3] The "deemer clause" exempts from the saving clause any state law which purports to regulate insurance and which deems a benefit plan to be engaged in the "business of insurance." The court of appeals fails to address in its opinion how benefit plans can be "mere agents" of insurance companies in the collection of "premiums" (plan benefit payments) and not be deemed to be in the business of insurance.

thus "go naked" with respect to excess risk or (ii) reduce assets available for the payment of benefits by paying the passthrough of the tax from the insurance company. This dilemma results from permitting states to define what insurance is and what is to be deemed a premium, which they can always do in a way designed indirectly to tax plan benefits, and conflicts with the general congressional policy of protecting the security and viability of employee benefits plans and the specific policy of protecting those plans from state taxation. The state's action here affects the plans' administration and may affect benefit levels. The tax at issue here is passed back to the benefit plans by the insurer. This could well result in the employers' offsetting this tax by lowering benefit levels. Such an action is contrary to the congressional policy underlying ERISA of encouraging the growth of benefit plans.

Such a tax could result in employers adopting different benefit formulae for employees inside states which indirectly tax benefit plan payments. Employers would therefore be required to accommodate conflicting schemes in different states by structuring and administering their plans differently in each state in which they have employees.

> Such a situation would produce considerable inefficiencies, which the employer might choose to offset by lowering benefit levels. As the Court in *Shaw* indicated, "ERISA's comprehensive preemption of state law was meant to minimize this sort of interference with the administration of employee benefit plans," *ibid.*, so that employers would not have to "administer their plans differently in each State in which they have employees." *Id.*, at 105, 103 S.Ct., at 2904 (footnote omitted).
>
> * * * * *
>
> A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with

existing plans to reduce benefits, and those without such plans to refrain from adopting them.

Fort Halifax Packing Co. v. Coyne, 107 S.Ct. 2211, 2217 (1987).

The incidence of the tax may fall upon insurers, but that is a distinction without a difference, because on its face the tax functions unambiguously as a tax on benefits paid directly out of employee benefit plans. The tax at issue is contrary to congressional intent and frustrates the policies underpinning ERISA. The devastating potential impact of the decision requires review and reversal by this Court.

The congressional policies undermined by the court of appeals' decision are expressed in the pre-emption provision, the provision exempting plans from state taxation and the deemer clause. The language and history of the insurance saving clause demonstrates that that provision does not vitiate the protection afforded by the first three provisions, and nothing in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) compels otherwise.

Congress clearly intended to pre-empt a state's ability to tax employee benefit funds. When ERISA was originally under consideration, Congress specifically rejected a recommendation from the Administration to remove state taxation from the pre-emption provision. Administration Recommendations to the House and Senate Conferees on H.R. 2 (April, 1974), *reprinted in* 3 Legislative History of ERISA 5050, 5147.

This intent was explicitly incorporated into ERISA by amendment in 1983. Section 514(b)(5)(B)(i) pre-empts "any state tax law relating to employee benefit plans."[4] The legislative history of this provision indi-

[4] The District Court below held that Congress intended Section 514(b)(5)(B)(i) to pre-empt state taxation of benefit plans, even if done indirectly as Respondents have done here. The Court of Appeals, however, never addressed Section 514(b)(5)(B)(i) in its decision.

cates that Congress intended to shield benefit plans from any form of state taxation, and that this intent was part of the original enactment. *See* House Conference Report No. 97-984, pp. 18, *reprinted in* U.S. Code Congressional and Administrative News, 1982, pp. 4580, 4603 ("Under the provision [514(b)(5)(B)(i)], preemption *is continued* with respect to (1) *any* State tax law relating to employee benefit plans . . .") (emphasis added). *See also Northwest Airlines Inc. v. Roemer*, 603 F. Supp. 7, 12 (D.C. Minn. 1984); *National Carriers' Conference Committee v. Heffernan*, 454 F. Supp. 914 (D.C. Conn., 1978) (holding that § 1144(b)(5)(B)(i) pre-empts state tax laws "relating to" ERISA).

The court of appeals acknowledged that the tax law at issue "relate[s] to benefit plans." App. 11a. The tax law thus runs afoul of the express terms of section 514 (b)(5)(B)(i) as well as the general policy against state taxation of benefit plans.

Additionally, the tax law conflicts with the language and purpose of the "deemer" clause, 29 U.S.C. § 1144 (b)(2)(B) which prohibits any benefit plan from being "deemed" to be in "the business of insurance" for the purpose of "any state law purporting to regulate insurance companies."

The legislative history of Section 514 makes the precise scope of the deemer clause clear:

> . . . it is our belief that the general policy of Section 514(a), excluding state regulation relating to ERISA covered plans, should not be disturbed. However, *it may be necessary to narrow the* exceptions to this policy which are described in Section 514(b). It has come to our attention that our efforts to ensure minimum disruption of the regulatory efforts of the states in the fields of insurance, banking, and securities, generally are being construed to raise to the level of a reservation of state authority over employee benefit plans themselves. The argument is predicated on an interpretation of the language

". . . shall be deemed . . ." as used in Section 514(b)(2)(B) to limit the scope of the prohibition contained therein to the use by State authority of *a legal fiction* to declare a plan to be insurance, or a trust company, etc., where it is not. As this line of reasoning goes, those plans which actually contain the characteristics of insurance, etc., would then remain subject to state regulation.

Such interpretation, while artful, is not supported by a fair reading of the statute and legislative history. Faced with the conflicting and uncertain basis for regulation among the states, *the "deemed" language was utilized to create an irrebuttable presumption that these plans are not insurance, trust companies, etc., for purposes of state regulation.* As a drafting technique the "deemed" is used in Section 514(b) not to bar the use of a legal fiction by the states but to create what may amount to a legal fiction in a given circumstance. *The irrebuttable presumption would not be overcome even if an employee benefit plan engages in activities which bring it within the insurance, trust, or securities activities generally regulated by a state.*

H.R. Report No. 94-1785, Report of the ERISA Oversight Task Force on Welfare and Pension Plans (1976), *reprinted in* House Reports Vol. 3-1C (1976) (emphasis added).

Congress intended to create an "irrebuttable presumption" of pre-emption by virtue of the "deemer" clause to prevent a state's use of a "legal fiction" to regulate a benefit plan. By "deeming" benefit plans or their employer sponsors to be "mere agents" of insurance companies in the collection of "premiums" (plan benefit payments) which are constructively passed to the insurance companies,[5] the state has "deemed" the benefits plans to

[5] In reaching its conclusion that benefits paid by employers directly to employees pursuant to the terms of a benefit plan constitute premiums constructively received by the plan's excess risk insurers, the California Supreme Court held that the employee

be in the business of insurance in violation of the deemer clause. A state court's novel construction of state insurance laws cannot, however, be controlling under ERISA or else by means of legal fictions states can eviscerate ERISA's pre-emption provisions.

It is of no moment that California attempts to intrude indirectly through a tax on insurance companies rather than directly. "ERISA makes clear that even indirect state action bearing on private pension plans [benefit plans] may encroach upon the area of exclusive federal concern . . . ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the pre-emption provision." *Alessi v. Raybestos-Manhattan Inc.*, 451 U.S. 504, 525 (1981). Pre-emption "requires us to consider the relationship between state and federal laws as they are interpreted and applied, not merely as they are written." *Jones v. Rath Packing Co.*, 430 U.S. 519, 526 (1977).

Despite the evident congressional intent to protect employee benefit plans from state taxation, the court of appeals misinterpreted section 514(b)(2)(A)—the insurance saving clause—to override the force of the pre-emption provisions. The court of appeals held that the saving clause "preserves the McCarran-Ferguson Act's reservation of the business of insurance to the states," and "McCarran-Ferguson, in turn preserves the states' ability to 'tax and regulate' insurance". App. 12a-13a.

Contrary to the court of appeals' reading of the saving clause, section 514(b)(2)(A) does not reserve the business of insurance to the states—it exempts from pre-emption state laws which "*regulate insurance.*" Nowhere

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benefit plans are "mere agents" of the excess risk insurers. *Metropolitan Life Ins. Co. v. State Board of Equalization*, 652 P.2d at 430. The court then concluded that these "agents" receive premiums from employees through the value of the employees' labor which somehow inures to the benefit of the excess risk insurer. *Id.* at 431-433.

does it exempt from pre-emption state laws which relate to "taxation." The McCarran-Ferguson Act itself specifically refers to the terms "regulation *or* taxation" and preserves both the "regulation" *and* "taxation" of the business of insurance to the states (20 U.S.C. § 1012(a), (b)).

This Court recently noted that "Congress' choice of language is significant" in ERISA. *Fort Halifax Packing Co. Inc. v. Coyne*, 107 S. Ct. at 2216.[6] The saving clause of ERISA's pre-emption provision does *not* refer to state laws relating to "taxation" but to state laws which "regulate" insurance. The words "tax" and "regulate" are used separately throughout ERISA, and nowhere in the statute are they treated as the equivalent of one another. There is a distinct difference between a law which "taxes" and one which "regulates." Congress' use of only the latter in the saving clause is significant.[7] Therefore,

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[6] The Court noted that "ERISA's pre-emption provision does not refer to state laws relating to 'employee benefits,' but to state laws relating to 'employee benefit *plans*.'" "The words 'benefit' and 'plan' are used separately throughout ERISA, and nowhere in the statute are they treated as the equivalent of one another. Given the basic differences between a benefit and a plan, Congress' choice of language is significant in its pre-emption of only the latter." (107 S. Ct. at 2216).

[7] While ERISA was under consideration by Congress it was assigned to the chief tax writing committee of each house (the Senate Finance Committee and the House Ways and Means Committee), and to the Joint Committee on taxation as well as to each house's respective labor committee.

The "ERISA Oversight Task Force on Welfare and Pension Plans" in its Report to Congress reiterated Congress' specific intent to *narrowly limit* the "saving clause" exception to preemption.

> There was a recognition of the necessity for the preservation of some state activity in this field and certain limited exceptions were made to the broad preemption scheme.
>
> * * * *
>
> These exceptions are designed to delineate affirmatively the limits of the "field" preempted by section 514(a), H.R. Report No. 94-1785, pp. 46-47 (1976).

by its very terms the saving clause of ERISA's pre-emption applies only to state laws which "regulate" insurance.

Moreover, for purposes of federal law the tax at issue does not relate to the business of insurance. This Court has stated that for purposes of federal law one element of whether a practice is part of the "business of insurance" and therefore subject to state regulation is whether there is a "transferring or spreading of a policyholder's risk." *Union Labor Life Ins. Co.* v. *Pireno*, 458 U.S. 119, 129 (1982). A "fundamental principle of insurance [is] that the insurance *policy* defines the scope of the risk assumed by the insurer from the insured." *Id.* at 131 (emphasis added). The insurer here bears *no* risk for payments below the trigger level—these remain the sole obligation of the employers' benefit plans. The only risk the insurer bears is under the excess risk policy it issued. *See, e.g.*, the well reasoned dissenting opinion of Mr. Justice Kaus of the California Supreme Court in *Metropolitan Life Ins. Co. v. State Board of Equalization*, 652 P.2d at 433. Therefore, as a matter of federal law and ERISA only the premiums for this excess risk policy are taxable by the state.

Finally, contrary to the court of appeals' assertion, *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), does not "require" permitting states to tax benefit plans if the initial incidence of the tax falls on insurance companies and not plans. *Metropolitan Life* involved state regulation of the *content* of insurance policies offered by insurance companies for sale, an area of traditional state insurance regulation. ERISA does not purport to prescribe the substantive content of employee welfare benefit plans, 471 U.S. at 732, and the state law concerning the content of an insurance policy purchased by such a plan thus did not conflict with any countervailing federal policy. Here by contrast the state law directly conflicts with and negates a specific and im-

portant federal policy, explicitly in other legislative provisions, against state taxation of plans.

CONCLUSION

For the foregoing reasons, the Chamber of Commerce, *amicus curiae*, respectfully suggests that the Court grant the petition for writ of certiorari and reverse the court of appeals' decision.

Respectfully submitted,

Of Counsel
STEPHEN A. BOKAT
NATIONAL CHAMBER
LITIGATION CENTER, INC.
1615 H Street, N.W.
Washington, D.C. 20062
(202) 463-5337

CARL L. TAYLOR *
JOHNSON & SWANSON
Columbia Square
Suite 660 West
555 Thirteenth Street, N.W.
Washington, D.C. 20004
(202) 383-8760

WILLIAM B. MCCLURE, JR.
J. GORDON CHRISTY
JOHNSON & SWANSON
900 Jackson Street
Dallas, Texas 75202-4499
(214) 977-9000

Counsel for the Chamber of Commerce of the United States, Amicus Curiae

* Counsel of Record

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

GENERAL MOTORS CORPORATION and
AMERICAN NATIONAL RED CROSS,
Petitioners,

v.

WILLIAM M. BENNETT, CONWAY H. COLLIS,
ERNEST J. DRONENBERG, JR., RICHARD NEVINS,
GRAY DAVIS, and BRUCE BUNNER,
Respondents.

**On Petition For Writ Of Certiorari
To The United States Court Of Appeals
For The Ninth Circuit**

REPLY BRIEF IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

Of Counsel:

STEPHEN M. SHAPIRO

MAYER, BROWN & PLATT
190 S. La Salle Street
Chicago, Illinois 60603
(312) 701-7327

PAUL D. INMAN

GIBSON, DUNN & CRUTCHER
1050 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 955-8500

STEPHEN E. TALLENT
*WILLIAM J. KILBERG

GIBSON, DUNN & CRUTCHER
1050 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 955-8500

Attorneys for Petitioners

**Counsel of Record*

PRESS OF BYRON S. ADAMS, WASHINGTON, D.C. (202) 347-8203

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REPLY BRIEF IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

Respondents cannot deny the only fact determinative here: in purporting to tax the business of insurance, they calculate the amount subject to tax by reference to the benefit amounts paid from ERISA plans. To justify that reference to ERISA benefits in the calculation of the tax, respondents purport to rely on record "fact," but actually rely on nothing other than the theory they originally invented to justify the tax under *State* law.

Respondents argue that "it is the insured employees that are actually paying the premiums for their insurance coverage through their labor." Brief in Opposition to Petition for Writ of Certiorari ("Opposition

Brief") at 7-8. From this theoretical premise—which neither the District Court nor the Court of Appeals thought worthy of mention—respondents assert that it is the value of these "labor premiums" that they seek to tax. The ERISA benefits, respondents thus conclude, are used solely as a way to quantify the value of these "labor premiums."[1] *Id.* at 11-12. Respondents must admit, however, that petitioners' employees do not work for Metropolitan Life Insurance Company. Thus, even if the value subject to tax is presumed to flow from employee to employer as "labor premiums" rather than from employer to employee as ERISA benefits, the value is still not received in fact by the insurance company. Indeed, it was this total absence of any actual nexus between the insurer and the "labor premiums" that compelled the California Supreme Court to declare that all employer sponsors of ERISA plans "are to be treated as agents of Metropolitan" as a matter—not of fact—but of California law. Appendix to Petition for Writ of Certiorari ("Pet. App.") at 51a.[2]

Similarly, respondents' attempt to convince the Court that their tax on ERISA benefits is "limited"

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[1] Respondents' theory erases the distinction, which the Court has recognized, between plans funded by employee contributions ("contributory plans") and plans funded by company assets ("noncontributory plans"). *See, e.g., International Brotherhood of Teamsters v. Daniel*, 439 U.S. 790, 793 (1979) ("noncontributory" plan found where "*employees paid nothing to the plan themselves*") (emphasis added). Respondents argue that the employees "paid" everything to the plan through their labor.

[2] Through the "agency" fiction, the State has transformed the plan into an extension of the insurance company and thus has accomplished precisely what Congress sought to foreclose by enacting the "deemer clause." 29 U.S.C. § 1144(b)(2)(B).

only to cases in which the benefits are "insured." Opposition Brief at 9. Indeed, it is fair to say that respondents' defense of their tax in this Court is grounded on the premise that the benefits upon which their tax is imposed are fully "insured" benefits. The District Court squarely held, however, that the insurance companies were *not* responsible, under the excess-risk arrangement, for benefits below the "trigger point." Pet. App. at 17a (petitioners "remain responsible for payment of all benefits from their respective plans below a trigger point"). The Court of Appeals agreed. *Id.* at 6a (petitioners "are responsible for paying all claims up to a trigger point").[3]

Moreover, whereas ERISA recognizes a distinction between *plans* that are "fully insured" and those which are "not fully insured"[4], it draws no distinction, and none can workably be drawn, among benefits based on the degree to which an insurance carrier may or may not be primarily, secondarily, wholly, or conditionally liable for a given benefit. Thus, respondents' assertion that the Court of Appeals' decision hinges on the "insured" status of the benefits is not based on any factual finding or legal determination below. If the decision below does turn, as respondents argue, on the Court of Appeals' implicit deference to the State's characterization of the benefits as "insured," then review is warranted to establish that such deference to state characterizations

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[3] Respondents' assertion that the "record" in this case establishes the "insured" status of the pre-trigger benefits is all the more remarkable because they appear simultaneously to contend that the "record" proves that there is no "insurance" risk below the "trigger point." Opposition Brief at 8.

[4] *See* 29 U.S.C. § 1144(b)(6)(A).

of ERISA benefits is antithetical to ERISA's preemption of state law.

Finally, respondents attempt to minimize their inclusion of benefits in the basis of the tax by characterizing it as a mere "arithmetical reference" for "purely computational purposes." Opposition Brief at 5, 6. As Justice Blackmun recognized, however, in *American Bank & Trust Co. v. Dallas County*, 463 U.S. 855 (1983), the "practical impact" of a tax computed by reference to an amount "is indistinguishable from that of a tax imposed directly on" that amount. *Id.* at 862.

The practical impact here is severe. Respondents have estimated that the State of California alone stands to gain $200 million to $300 million from back "labor premium" taxes. R. Finlayson, "California Court Levies Tax on Self-Funded Plan," *Business Insurance*, June 8, 1987, at 1, col. 1. Insurance companies have provided excess-risk insurance to plans in California only under the condition that the plans reimburse them for the full cost of a tax imposed on "labor premiums," which they never receive. Because there is no reason to believe that other states will fail to follow California's example, the cost of employer-sponsored health care will increase staggeringly as a consequence of the decision below to the detriment of employees, their dependents, and, most relevant here, the federal interest Congress sought to protect through its enactment of section 514 of ERISA.[5]

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[5] Respondents claim that *Fort Halifax Packing Co., Inc. v. Coyne*, 107 S. Ct. 2211 (1987), demonstrates that "the pre-emption clause is not applicable in this case." Opposition Brief at

CONCLUSION

In the guise of factual presentation, respondents reassert a theory of taxation upheld by the California Supreme Court in a 4-3 decision reversing the lower California courts. That theory serves to make all ERISA benefit activity tantamount to the business of insurance. Plan participants are "insureds," plan sponsors are "insurance agents," and plan benefits are "gross premiums" because they express the value of the "insureds'" "labor premiums." In the words of the California Supreme Court's dissenting opinion: "Article XIII, section 28 of the California Constitution imposes a tax on (1) gross *premium*, (2) *received* by (3) an *insurer*. The majority imposes this tax on (1) *losses* (2) *paid* to (3) *doctors and hospitals* and the like. What went wrong?" Pet. App. at 55a.

The same question, with the same tone of incredulity, applies to the decision of the Court of Appeals. ERISA exempts from preemption laws that (1) regulate (2) insurance (3) other than the "insurance" inherent in the nature of the ERISA plan. 29 U.S.C. § 1144(b)(2). The Court of Appeals applied the exemption to save a law that (1) taxes (2) ERISA ben-

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18. *Fort Halifax*, however, merely held that a state law requiring a one-time, lump-sum, plant-closing severance payment did not thereby require the employer to establich an ERISA plan or otherwise "relate to any employee benefit plan." Nothing in *Fort Halifax* ever arguably supports respondents' silly argument that their tax is not preempted because it "relates" only to ERISA benefits and not to the ERISA plans providing those benefits.

Similarly without merit are respondents' standing and Tax Injunction Act arguments, which both the District Court and the Court of Appeals soundly rejected. Pet. App. at 7a-10a; 19a-20a.

efits (3) on the theory that such benefits entail an inherent cost of "insurance." What went wrong? Unless this Court answers that question, an intentionally narrow exception to the rule of preemption will have become the means for the unrestrained state taxation of plan assets.

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Respectfully submitted,

Of Counsel:

STEPHEN M. SHAPIRO

MAYER, BROWN & PLATT
190 S. La Salle Street
Chicago, Illinois 60603
(312) 701-7327

STEPHEN E. TALLENT
*WILLIAM J. KILBERG

GIBSON, DUNN & CRUTCHER
1050 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 955-8500

Attorneys for Petitioners

**Counsel of Record*

PAUL D. INMAN

GIBSON, DUNN & CRUTCHER
1050 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 955-8500